

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 8 3 3 8

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
STEVEN		GREG		ADAMS			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	March 17, 1961	18 YRS.			JULY 28 1979	332 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Penna.	U.S.A.			WASHINGTON MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Washington Co. Hospital			Upholster		Upholstery	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Penna.	Franklin	Chambersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	736 South Second Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Kenneth L. Adams, Sr.		Joyce Eckstine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		200-52-2731		K.L. Adams, Sr. 736 S. 2nd St. Chambersburg, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) EB12 MOTOR VEHICLE TRAFFIC ACCIDENT							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
(b) INVOLVING COLLISION WITH ANOTHER							2 HRS
DUE TO, OR AS A CONSEQUENCE OF							
(c) MOTOR VEHICLE							30 MINS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
{MASSIVE HEAD TRAUMA AND BRAIN STEM INJURY}							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR		VEHICLE RAN RED LIGHT-STRUCK AUTO			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, ETC.)		21f. LOCATION			
		STREET		FRANKLIN AT JOHATHAN ST WASH MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		SIGNATURE	
Edward W. Ditto III		DEPUTY		JULY 28 1979			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Edward W. Ditto III MD		217 W. Washington St. Hager, Md 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		July 31, 1979		Parklawns Mem. Gardens		CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE	
		John O. Park		152 S. 2nd St. Chambersburg, Pa.		1979	

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. IF THE DEATH IS SUSPECTED TO BE A BUREAU OF INVESTIGATION CASE, PAGE 3 SHOULD BE USED AS A BUREAU-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 8 3 3 9

1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE H.		LAST Allen		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH July		DAY 25		YEAR 1979		2b. HOUR P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH AUG.		DAY 14		YEAR 1915		6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD July 25 1979 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co.								MD	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) R.D. #5		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Auto Sales											
13a. STATE Penna.		13b. COUNTY Franklin		13c. STREET ADDRESS Green Ridge Summit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 429									
14. FATHER'S NAME FIRST Robert		MIDDLE J.		LAST Allen		15. MOTHER'S MAIDEN NAME FIRST Bertha		MIDDLE Huff									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 174-01-3933A		17. INFORMANT Mary Allen		ADDRESS Box 429 Blue Ridge Summit, Pa.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8120 Motor vehicle collision with another motor vehicle		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 1:30 P.M. July 25 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Collision with another car Throwing driver out of car													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Hiway		21f. LOCATION STREET Intersection RT 418 & RT 64		CITY OR TOWN WASH RD		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE David H. Moore		TITLE (SPECIFY) Dep		M.D.		MEDICAL EXAMINER		DATE SIGNED July 25 1979									
EXAMINER'S NAME (TYPE OR PRINT) Howard N. Weeks		ADDRESS 580 Northern Ave Hagerstown															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/28/1979		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION CITY OR TOWN Waynesboro		COUNTY Franklin		STATE Penna.							
24. FUNERAL DIRECTOR David H. Moore		ADDRESS 50 S. Broad St., Waynesboro, Pa.		25a. DATE REC'D. BY REGISTRAR JUL 31 1979		25b. REGISTRAR'S SIGNATURE Dorothy McBratney											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 9 18340							
1 DECEASED NAME (TYPE OR PRINT)		2a DATE OF DEATH				2b HOUR			
FIRST MIDDLE LAST Janice Marlene Baker		MONTH DAY YEAR July 19 79				11:55 AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
female		white		MONTH DAY YEAR Sept. 10, 1934		44 YRS		IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Washington MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		541 Frederick Street	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Alton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Wolf					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Alice Sue Decker, Fairplay, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> 1809 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>METASTATIC CEREBRAL CARCINOMA</u> (c) <u>RENAL INSUFFICIENCY</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 12</u> 19 <u>79</u> to <u>July 19</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>July 15</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
C. D. Wooster		MD						7/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
C. D. Wooster									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		July 22, 1979		Boonsboro Cemetery		Boonsboro, Wash., Maryland			
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home		JUL 24 1979				Lester K. Kline			
415 E. Wilson Blvd., Hagerstown, Md. 21740									

BP

27-1-19

BP _____
DHMH - 16 50M 1/76
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 8 3 4 1					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELVA VIRGINIA BARNHART					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 7 28 '79 6 A. M.					
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 18, 1912		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 67		7. IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Hymond E. Sharon					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Etta Gross					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-09-7592		17 INFORMANT Gloria J. Crumbacker		ADDRESS 5 Avalon Avenue Hagerstown, Md.				
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (we) (this hospital) attended the deceased from March 19 79 to 28 July 19 79 , that (we) last saw the deceased alive on 28 July 19 79 , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dalton M. Welty M.D.				DEGREE M.D.				22c. DATE SIGNED 7/28/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS						
Dalton M. Welty M.D.				998 Potomac Avenue, Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-31-79		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.				
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc. Hagerstown, Md.				25a. DATE REC'D. BY REGISTRAR AUG 1 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 3 4 2

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) GERALD M. BITTINGER			2a. DATE OF DEATH MONTH DAY YEAR JULY 5 1979			2b. HOUR 9:23 P.M.			
3 SEX MALE		4 RACE CAUC.		5 DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Fireman		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Chambersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 355 Route # 2	
14 FATHER'S NAME FIRST MIDDLE LAST William Bittinger		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara McClure				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W W II			
16b. SOCIAL SECURITY NO. 179-12-4984		17 INFORMANT ADDRESS Pa. 17201				17 R.L. Bittinger Box 355 Route # 2 Chambersburg			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PONTINE HEMORRHAGE 431- DUE TO, OR AS A CONSEQUENCE OF b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1979 to July 5, 1979 , that (I) (we) lost saw the deceased alive on July 5, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. Byrd				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5 July 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. BYRD				22e. ADDRESS 1190 Mt. Aetna Rd. Hagerstown					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 10, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Franklin Pa.			
24 FUNERAL DIRECTOR NAME ADDRESS John O. Park 152 S. 2nd St. Chambersburg, Pa.				25a. DATE REC'D. BY REGISTRAR JUL 13 1979		25b. REGISTRAR'S SIGNATURE <i>Robert McClure</i>			

MEDICAL CERTIFICATION

9
9

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 1 8 3 4 3

1. DECEASED NAME (TYPE OR PRINT) Charles E. Boward			2a. DATE OF DEATH MONTH DAY YEAR July 9 1979			2b. HOUR 1:25A M				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 29 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine operator		12b. KIND OF BUSINESS OR INDUSTRY Machine Co.		
13a. STATE Md.			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST George W. Boward			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Cunningham			13e. STREET ADDRESS Box 290 R.D. #5				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 173-03-3157		17 INFORMANT Flora Boward				ADDRESS Box 290 R.D. #5 Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hyperkalemia</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <u>End-stage renal disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Acute renal failure secondary to heart failure</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION 7/3/79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Skelemic ulcer leg, left			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) the hospital attended the deceased from <u>APRIL 19 71</u> , to <u>7/8 19 79</u> , that (I) we last saw the deceased alive on <u>7/8 19 79</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did not view the body after death.										
22b. SIGNATURE <u>John R. Marsh</u> 22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. MARSH						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/9/79		
22d. ADDRESS <u>239 N. Potomac St.</u> <u>HAGERSTOWN, MD 21740</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/11/1979		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Franklin Penna.			
24. FUNERAL DIRECTOR <u>David J. Moore</u>						ADDRESS 50 S. Broad St. Waynesboro, Pa.		25a. DATE REC'D. BY REGISTRAR JUL 16 1979		
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>										

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RIGHTS

WATER RIGHTS

10



WATER RIGHTS

11

WASHINGTON, D. C.

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C.

WASHINGTON, D. C.

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		7 9 1 8 3 4 4 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Michael Virgil Boward					2a. DATE OF DEATH MONTH DAY YEAR July 30, 1979			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-6-1892		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) brick layer		12b. KIND OF BUSINESS OR INDUSTRY construction		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James William Boward					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen - - Cline					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW 1				16b. SOCIAL SECURITY NO. 214 09 2948		17. INFORMANT ADDRESS Mrs. Nora Martin see # 13				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>severe obstructive airway disease</u> (c) <u>coronary artery disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from <u>7/21/79</u> to <u>7/30/79</u> , that (I) (we) lost <u>1979</u> saw the deceased alive on <u>7/21/79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22a. SIGNATURE <u>Charles Hooster</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. D. Hooster</u>					22e. ADDRESS <u>1825 Howell Rd -</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 3, '79		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland				
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		305 N. Potomac St. Hagerstown, Maryland		25a. DATE RECD. BY REGISTRAR AUG 8 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 1 8 3 4 5	
FOR 1 - STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Betty Elizabeth BOWERS						2a. DATE OF DEATH MONTH DAY YEAR 7 29 1979		2b. HOUR 8 AM			
3. SEX F.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 3 9 39		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. G.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. G. Hospital.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wash. 13c. CITY OR TOWN Hagerstown.						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 49 Hump Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST James Ranklin Hensell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Snyder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ronald L. Bowers 49 Hump Rd. Hag., MD 21740					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Breast 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE Eric M. Wapshal						DEGREE		22c. DATE SIGNED 7/29/79		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric M. Wapshal						22e. ADDRESS 1708 Oak Hill Ave. Hag., MD 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b. DATE Aug. 1, 1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington MD			
24. FUNERAL DIRECTOR NAME Osborne Funeral Home wmspl, MD				ADDRESS P.O. Box 348		25a. DATE REC'D. BY REGISTRAR AUG 14 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)						MONTH DAY YEAR				HOURS MIN	
Robert Edward Brandt Sr						7 10 79				730A	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		White		MONTH DAY YEAR		51		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown				Washington County Hospital				carpenter		Crampton Contr.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		117 E. Baltimore St. Funkstown			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME					
Charles Edward Brandt						Gladys Lorretta Balitho					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>				216-22-2078		Mrs. Doris Brandt 117 E. Baltimore St. Funkstown					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410- myocardial Infarction										Immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										4 yr	
(b) Coronary Sclerosis											
(c) Generalised Arteriosclerosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 74 to 7/10/79, that (I) (we) lost saw the deceased alive on 6/18/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
Robert Vh Campbell MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7/10/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Robt. Vh Campbell						Hagerstown MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
burial				July 12, 1979		Cedar Lawn Cemetery		Hagerstown Washington MD			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Osborne Funeral Home P.O. box 348 Wmspt., MD						JUL 17 1979		Lillian McCreedy			

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(VR AT15 ME) 15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18347

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) melvin Henry Byrum			7a. DATE KNOWN OF DEATH ESTI- MATED July 27 1979		7b. HOUR 11 P.M.
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4-28-13 66	6. AGE (IN YEARS) LAST BIRTHDAY 66 YRS.	7. UNDER 1 YR. MONTHS DAYS 0 0	7c. DATE PRONOUNCED DEAD July 27 1979
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Co. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PACKER	
13a. STATE Md		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST UNK.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia — Byrum		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 215 20 9449		17. INFORMANT ADDRESS Viola A. Byrum See #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE H.N. Weeks		TITLE (SPECIFY) Dep		DATE SIGNED JUL 28 '79	
EXAMINER'S NAME (TYPE OR PRINT) H.N. Weeks		ADDRESS Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-31-79		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
24. FUNERAL DIRECTOR NAME Gerald N. Minnick		ADDRESS 305 N. Potomac St. Hagerstown, Md		25a. DATE REC'D. BY REGISTRAR AUG 8 1979	
23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Robert M. Brady			

1 1 2 8 1



DELETED

NOXATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 8 3 4 8

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Margaret R. Buchanan			2a. DATE OF DEATH MONTH DAY YEAR 7 27 79			2b. HOUR 12:25 PM				
3 SEX female		4 RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 21 93		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.				
10 CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney-Heedy Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Guardette		12b. KIND OF BUSINESS OR INDUSTRY Fairchild.		
13a. STATE Md.			13b. COUNTY Wash.		13c. CITY OR TOWN Smithsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 3, Box 165	
14 FATHER'S NAME FIRST MIDDLE LAST Daniel Middle hauff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Downin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 231-01-9286		17 INFORMANT ADDRESS Fahrney Heedy Home, Boonsboro Md.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic obstructive disease 4371 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indefinite		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July , 19 74 , to July 27 , 19 79 , that <u>we</u> (we) last saw the deceased alive on July 13 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE B. B. Kneisley			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/27/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. B. Kneisley			22e. ADDRESS 148 West Wash. St. Hagerstown Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 30, 1979		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME Minnich Funeral Home			415 E. Wilson Blvd., Hagerstown, Maryland 21740			25a. D. AUG 0 1979		25b. REG. 18348		

64081



CHRONIC OBSTRUCTIVE PULMONITIS

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23 101 53

x

1. FULL NAME OF DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740	2. DATE REC'D. BY REGISTRAR JUL 12 1979	3. REGISTRAR'S NAME <i>Anthony McCready</i>
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100-100-100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 18350	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>John William Burkett</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>7-9-79</u>			2b. HOUR <u>11:10 P</u>		
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YR <u>7 13 08</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.					
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Western Maryland Center</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Custodian</u>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <u>New York</u>		13b. COUNTY <u>Albany Co.</u>		13c. CITY OR TOWN <u>Albany</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>William H. Burkett</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Elizabeth Meadows</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>107-10-2251</u>		17. INFORMANT ADDRESS <u>Elizabeth Pitsnogle, 523 Church St. Hagerstown, MD 21740</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of esoph-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>agus</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1509 weeks</u> <u>1978</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Tracheal obstruction</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-5-79</u> to <u>7-9-79</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>7-9-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE <u>Edwin G. Riley M.D.</u>						22c. DATE SIGNED <u>7-9-79</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS <u>Edwin G. Riley MD 1500 Penna Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>July 12, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown, Wash., Maryland</u>		24. FUNERAL DIRECTOR NAME ADDRESS <u>Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740</u>			
25a. DATE RECD. BY REGISTRAR <u>JUL 12 1979</u>						25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>					

MEDICAL CERTIFICATION



222

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

18351

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIE CATHERINE BURNS			2a. DATE OF DEATH MONTH DAY YEAR JULY 05, 79			2b. HOUR 8 1/2 A.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 7, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 340 Sherwood Drive	
14 FATHER'S NAME FIRST MIDDLE LAST Oscar C. Shroyer				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evva M. Rice					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-18-0771		17 INFORMANT ADDRESS Paul E. Burns, Sr., 340 Sherwood Drive					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION, SUSPECTED 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NONE									
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from JULY 1, 1979 to JULY 5, 1979 , that (b) (we) lost saw the deceased alive on JULY 5, 1979 , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) did (did not) view the body after death.									
22b. SIGNATURE Barry M. Cohen				DEGREE M.D.				22c. DATE SIGNED 7-5-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN				22e. ADDRESS 138 E ANTIETAM ST HAGERSTOWN, MD. 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 7, 1979		23c. NAME OF CEMETERY OR CREMATORY Myersville U.M. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Myersville, Wash. Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 9 1979					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 18352	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		2c. MIN.	
		Paul Leroy Carbaugh				7 31 79		9 30		A M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		June 3, 1909		70 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington County		Laborer		Cement					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Washington		Clearspring		YES		S. Martin St.			
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
Robert W. Carbaugh		Effie O. Repp		Yes		WW-2		Mrs. Carol Alexander Williamsport			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629		CARDIORESP. ARREST				PROBABLE Bronchogenic carcinoma		Severe Emphysema			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/16/ 19 79, to 7/31/ 19 79, that (I) (we) last saw the deceased alive on 7/31/ 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
L. D. Wooster		MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		7/31/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
L. D. WOOSTER		1825 Howell Rd Hagerstown Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Aug. 3, 79		Blairs Valley		Clearspring, Wash. Md.					
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Donald E. Thompson		AUG 6 1979		Jeffrey McBrady							
Thompson Funeral Home Clearspring, Md.											



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "NOTICE" and "MAY" are faintly visible.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8353	
1- STATE REGISTRAR										20. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) Charles James Cavanaugh										20. DATE KNOWN OF DEATH 7-14-79	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH Oct. 29, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington		21. DATE PRONOUNCED DEAD 7-14-79		21. HOUR 0555	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mason Dixon Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) dock worker		12b. KIND OF BUSINESS OR INDUSTRY Trucking		MD.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1824 Burnside Avenue			
14. FATHER'S NAME (FIRST MIDDLE LAST) Charles Hubert Kavanaugh						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Lula Virginia Ward					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Korean War				16b. SOCIAL SECURITY NO. 231-34-5469		17. INFORMANT ADDRESS Mrs. Elsie Cavanaugh, Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: Massive crush injuries, abdomen										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
IMMEDIATE CAUSE (a) 9192 DUE TO, OR AS A CONSEQUENCE OF with resultant exsanguination											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 0500 A.M. 7-1-3-79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) upset of a tow motor					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) terminal		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) Mason-Dixon Dr., Hagerstown, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE E. Hawbaker				TITLE (SPECIFY) Dep.				DATE SIGNED 7-14-79			
EXAMINER'S NAME (TYPE OR PRINT) E. Hawbaker, M.D.				ADDRESS 645 e. 1st St, Hagerstown, Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 16, 1979		23c. NAME OF CEMETERY OR CREMATORY Sunset View Mem. Gardens				23d. LOCATION (CITY OR TOWN COUNTY STATE) Woodstock, Shenandoah, Va.	
24. FUNERAL DIRECTOR NAME Minnich Funeral Home						25a. DATE REC'D. BY REGISTRAR JUL 19 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy			
415 East Wilson Blvd., Hagerstown, Maryland											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 3 5 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
Clara Mabel Chapman				June 22, 1979		845 P M				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Female	White	December 15, 1893		85 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
South Carolina	U.S.A.			Washington MD						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown	Washington County Hospital		Housewife		Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Washington		Sharpsburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. Main St.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Jacob		Easler		VNH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
no				Hugh D. Chapman		PO box 175 Sharpsburg, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Marked Debility C. Scleroderma										
4140 DUE TO (b) A CONSEQUENCE OF Perinatal arterial sclerosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) OR AS A CONSEQUENCE OF Perinatal arterial sclerosis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from June 8, 1979, to June 22, 1979, that (I) (we) last saw the deceased alive on June 22, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.										
22b. SIGNATURE Sidney H. Hovestetter MD		22c. DATE SIGNED 6-25-79		22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY HOVESTETTER		22e. ADDRESS FUNKSTOWN MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE June 25, 1979		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery Sharpsburg Washington MD		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME		24. ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Osborne Funeral Home PO Box 348 Wmspt., MD				JUL 17 1979		Sidney H. Hovestetter				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 60M 1/75
(VR A 15 (4))

1- FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 9 1 8 3 5 5	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Fred McCalma Cole				July 2, 1979 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS	
Male	Caucasian	April 26, 1900		79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	U.S.A.			Washington County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Hagerstown	Washington County Hospital		Dist. Sales Rep. Insurance		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS
Maryland		Washington	Hagerstown	8 Marbern Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
John Albert Cole		Gertrude Trumpower			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES)		17. INFORMANT ADDRESS	
No		214-09-8259		Pauline G. Cole, 8 Marbern Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute respiratory failure.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
5-191 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe obstructive bronchopulmonary disease & emphysema.</u> DUE TO, OR AS A CONSEQUENCE OF (c)					<u>Unknown</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic heart disease, right bundle branch block, & 2 treated episodes of subacute bacterial endocarditis; transitional cell carcinoma of urinary bladder (1977).</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		cell carcinoma of urinary bladder (1977).			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10 Feb.</u> , 19 <u>69</u> , to <u>2 July</u> , 19 <u>79</u> , that (I) <u>lost</u> saw the deceased alive on <u>18 May</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Clovis M. Snyder</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/2/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Clovis M. Snyder, M.D.</u>		22e. ADDRESS <u>106 North Potomac St. Hagerstown, Md. 21740</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>7-5-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery Hagerstown, Wash., Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Rest Haven Funeral Chapel, Inc., Hag., Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 6 1979</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 8 3 5 6

1. DECEASED NAME (TYPE OR PRINT) Roscoe, Creager			2a. DATE OF DEATH MONTH DAY YEAR 7-6-79		2b. HOUR 1:20 PM
3 SEX M	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3-30-93	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Avalon Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner & Operator	12b. KIND OF BUSINESS OR INDUSTRY Hardware	
13a. STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hancock	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Timber Ridge #2
14. FATHER'S NAME FIRST MIDDLE LAST Harry L. Creager			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Kate Ditto		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 30 9121	17. INFORMANT ADDRESS Rhoda Belle Vantz 159 W. High St. Hancock Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Inf. Vena Cava 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - Generalized DUE TO, OR AS A CONSEQUENCE OF (c) Degenerative Brain Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Degenerative Brain Disease					
19a. DATE OF OPERATION 1976		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Aortic Aneurysm		20a. AUTOPSY? NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 28, 1979 to July 6, 1979 , that (I) (we) last saw the deceased alive on July 6, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Phyllis A. Hoffman		DEGREE MD		22c. DATE SIGNED 7-7-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Phyllis A. Hoffman		22e. ADDRESS 1147 Oak Hill Ave, Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 9 1979	23c. NAME OF CEMETERY OR CREMATORY St. Thomas Episcopal		23d. LOCATION CITY OR TOWN COUNTY STATE Hancock Washington Md.
24. FUNERAL DIRECTOR NAME Richard J. Stone		ADDRESS Hancock Md.		25a. DATE REC'D. BY REGISTRAR JUL 13 1979	
				25b. REGISTRAR'S SIGNATURE Hofney McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

18-18357

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT NMN CUTSHAW			2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1979		2b. HOUR MIN 15 A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR October 14, 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 75 -	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hag. Shoe Co. Mfg. Shoes		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Elizabeth Cutshaw		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-5078		17. INFORMANT ADDRESS Mrs. Rose Kaylor, Rt. 3, Box 40	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis 5570 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis, Generalized DUE TO, OR AS A CONSEQUENCE OF (c) YENES					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Arteriosclerotic Heart Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 24 Jan 19 70 to 13 July 19 79 , that (I) (we) last saw the deceased alive on 13 July 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. N. Fender				22c. DATE SIGNED 14 July 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. Fender				22e. ADDRESS 138 E Antietam St. Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-17-79		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown, Wash., Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS Rest Haven Funeral Chapel, Inc., Hag.,		25a. DATE REC'D. BY REGISTRAR 18 1979		25b. REGISTRAR'S SIGNATURE Robert M. [Signature]	

BP



Item #18a Film G536 10/11/79
 FOR
 1- STATE REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18358
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR P.M.			
		Marvis		Miriam		DARLINGTON						JUL.		5		1979		9:00 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR A.M.	
female		white		Jan. 16, 1921		58 YRS.						JULY		6		1979		8:00 A.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
West Virginia				USA								Washington									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown				Washington County Hospital								billing clerk				trucking co.					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS					
13a. STATE												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				203 W. Baltimore Street					
13b. COUNTY																					
13c. CITY OR TOWN																					
Hagerstown																					
14. FATHER'S NAME FIRST MIDDLE LAST								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
John M. Darlington								Mabel E. Penrell													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)								16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS									
No								235-12-1811				Meredith Darlington, Baltimore, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>2252</u> Meningioma Left Cerebellopont angle, Post Terior Fossa																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) Hydrocephalus secondary to Meningioma																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
Coronary Atherosclerosis, focal																					
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
								P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>								21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>								TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER								DATE SIGNED JULY 9, 1979					
EXAMINER'S NAME (TYPE OR PRINT)								ADDRESS													
EDWARD W. DITTO, III, M.D.								217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND													
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
burial				July 10, 1979				Rose Hill Cemetery				Hagerstown, Washington, Md.									
24. FUNERAL DIRECTOR NAME ADDRESS												25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740												JUL 12 1979				<u>John H. Crady</u>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18359

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		ESTI- MATED		MONTH DAY YEAR		2b. HOUR AM PM	
MARIETTA LEA DAVIS				JULY 28 1979						4:15 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR AM PM
F	W	8-13-55		23 YRS.					JULY 29 1979		5:35 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Maryland		USA				Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		DOA Washington Co. Hospital				homemaker		home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Washington		Fairplay				Rt. 1 Box 153			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Charles Edward Davis				Esta Lee Rowe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT			
no				--				Marie Myers Hagerstown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) E821 - MOTOR VEHICLE NONTRAFFIC ACCIDENT										IMMED.	
DUE TO, OR AS A CONSEQUENCE OF											
(b) INVOLVING COLLISION WITH STATIONARY OBJECT											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
CRUSHING CHEST INJURY AND SKULL FRACTURE											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				4:15 JUL. 28 1979		CRUSHED IN BED WHEN AUTO CAME THROUGH WALL OF HOME					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				HOME		Rt. #64, FAIRPLAY, WASHINGTON, MD.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Edward W. Ditto, III				DEPUTY MEDICAL EXAMINER				JULY 29, 1979			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
EDWARD W. DITTO, III, M.D.				217 WEST WASHINGTON STREET HAGERSTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		7-31-79		Manor Church Cem.		Fairplay Wa. Maryland					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Gerald N. Minnich Hagerstown, Maryland				AUG 8 1979		[Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 18360

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOURS MIN.	
Russell Ferry DEATRICH		July 11, 1979		6:15 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	MONTH DAY YEAR	82	Washington MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
Pennsylvania	U.S.A.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Boonsboro	Reeder's Memorial Home		Laborer		Road Dept.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.	Wash.	Hagerstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	415 Mayfair Avenue	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Bert Deatrich		Sarah Dickson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		220-16-3685		Mr. Russell J. Deatrich, Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u>					15-20 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Disense</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 18</u> , 19 <u>79</u> , to <u>July 11</u> , 19 <u>79</u> , that (I) was lost the deceased alive on <u>June 20</u> , 19 <u>79</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) was not (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Edward W. Ditto III M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		July 12, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Edward W. Ditto III M.D.		217 W. Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		July 13, 1979		Cavetown Cemetery	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
Cavetown, Wash.		Md.		Md.	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D BY REGISTRAR	
<u>Dennis L. Davis</u>		Davis Funeral Home, Smithsburg, Md.		JUL 16 1979	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR										
REG. NO. 79 18361										
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beulah Irene DUNKIN					2a. DATE OF DEATH MONTH DAY YEAR July 18, 1979		2b. HOUR 4:50P M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY, MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own Home		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b COUNTY Frederick		13c CITY OR TOWN Myersville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John C. PALMER					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Unknown		17 INFORMANT ADDRESS Guy C. Dunkin (Son), Route 3, Box 189, Smithsburg, Maryland 21783						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 4340 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 DAY										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETIS MELLITUS PARKINSONS OSTEOPOROSIS										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/19, 1974 , to 7/18, 1979 , that (I) (we) lost saw the deceased alive on 7/18, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. Amarillo				DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/18/79		
21d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO				22e. ADDRESS 127 KING ST HAGERSTOWN MD 21740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/21/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lantz, Frederick, Maryland				
24. FUNERAL DIRECTOR NAME Charles Wm. Miller Funeral Home,				ADDRESS 104 East Main Street, Thurmont, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE Helen M. Brady		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					7 9 1 8 3 6 2 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Margaret Elizabeth Fritz					2a. DATE OF DEATH MONTH DAY YEAR July 26, 1979			2b. HOUR p. 10:15 M.		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 24, 1902		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Barlup					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie Walters REX Barlup					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Pauline Gabriel, 108 Clinton Ave.						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>min.</u> <u>2d</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>Uremia</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 79</u> to <u>26 July 19, 79</u> , that (I) <u>was</u> last saw the deceased alive on <u>26 July 19, 79</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above; (I) <u>did not</u> view the body after death.										
22b. SIGNATURE <u>J. D. Wilson, M.D.</u> DEGREE				22c. DATE SIGNED <u>7/27/79</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson, M.D.				22e. ADDRESS 580 Northern Ave., Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-30-79		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.				
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.				25a. DATE REC'D. BY REGISTRAR AUG 01 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR					REG. NO. 7 9 1 8 3 6 3				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES HAROLD HOFF					2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR July 15, 1979 5:00 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 29, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 72		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Pangborn	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN Maryland Washington Hagerstown					13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 23 S. Burhans Blvd.		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Goff					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Birdie May Weaver				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-10-4866		17. INFORMANT ADDRESS Mrs. Helen E. Goff, 23 S. Burhans Blvd.					
18. CAUSE OF DEATH Enter only one cause per part. Part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410 - DUE TO OR AS A CONSEQUENCE OF Anterolateral Heart Disease chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Unilateral Anterolateral DUE TO OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Putrifying Gangrene									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-15-79 , 19____, to 7-15-79 , 19____, that (I) (we) last saw the deceased alive on 7-15-79 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE D. Nardizabek					22c. DATE SIGNED 7-15-79			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. N. Nardizabek					22e. ADDRESS 387 John Cleveland Highway, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-18-79		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Rest Haven Funeral Chapel, Inc., Hag., Md.					25a. DATE REC'D. BY REGISTRAR JUL 19 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 8 3 6 4

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Harold Grossnickle			2a. DATE OF DEATH MONTH DAY YEAR July 4, 1979		2b. HOUR M
3. SEX Male	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR Feb. 16, 1924	6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a. USUAL OCCUPATION (PER OF WORK OR MOST OF WORKING LIFE) Supervisor	12b. KIND OF BUSINESS OR INDUSTRY State Roads	
13a. STATE Maryland			13b. CITY OR TOWN Frederick	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. # 2
14. FATHER'S NAME FIRST MIDDLE LAST Upton W. Grossnickle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Green		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-36-3403	17. INFORMANT ADDRESS Agnes Grossnickle Rt. # 2 Myersville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis 1579 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 78 , to 19 79 , that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE Wilson, MD		DEGREE		22c. DATE SIGNED 7/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/7/79	23c. NAME OF CEMETERY OR CREMATORY Grossnickle's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Myersville, Frederick Md.
24. FUNERAL DIRECTOR Battle Funeral Home Lawrence E. Battle			25a. DATE REC'D. BY REG. STAR JUL 9 1979		25b. RECEIVED BY Bartholomew

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post mortem examinations must be reported to the health department within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 8 3 6 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Downey Isiah Harshman						2a. DATE OF DEATH MONTH DAY YEAR July 26, 1979		2b. HOUR 10:38 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 5, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 75		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR COUNTY) Wolburn, Wash. Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rfd. 1 Box 286	
14. FATHER'S NAME FIRST MIDDLE LAST Alvey Harshman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myra Downey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 215-36-6580		17. INFORMANT ADDRESS Mr. Downey C. Harshman, Jr. Rfd. 1 Williamsport, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) None									
19a. DATE OF OPERATION 7-30-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Myocardial Infarction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Myocardial Infarction					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Williamsport Md.					
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 59 to July 27 79 , that (I) (was) last saw the deceased alive on July 23 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M. E. Byrkit MD				22c. DATE SIGNED July 27-79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. E. Byrkit MD	
22e. ADDRESS Williamsport Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-30-79		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md. 21713						25a. DATE REC'D. BY REGISTRAR JUL 30 1979			
						25b. REGISTRAR'S SIGNATURE Henry McCreedy			

MEDICAL CERTIFICATION

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1. DECEASED NAME (TYPE OR PRINT) Edgar Winfield Hawbecker				20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> July 13 1979				26. HOUR OF DEATH 3:30 P.M.											
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 13, 1933		6. AGE (IN YEARS) (LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YR. MONTHS DAYS 0 0		8. IF UNDER 24 HRS. HOURS MIN. 0 0		21. DATE PRONOUNCED DEAD MONTH DAY YEAR July 13 1979		24. HOUR OF DEATH 8:30 P.M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Washington				MD.			
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Electric							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE Maryland				13b. COUNTY Washington				13c. CITY OR TOWN Clearspring				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS RFD-1			
14. FATHER'S NAME FIRST MIDDLE LAST Chester Hawbecker												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Pensinger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW-2				16b. SOCIAL SECURITY NO. 216-30-3377				17. INFORMANT ADDRESS Mrs. Nancy Hawbecker Clearspring											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Severe Coronary Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one day months																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION none				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? none								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) none											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) None				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Francisco G. Japzon				TITLE (SPECIFY) Asst.				MEDICAL EXAMINER 645 E. First St. Hagerstown, Md. 21740				DATE SIGNED July 14, 1979							
EXAMINER'S NAME (TYPE OR PRINT) Francisco G. Japzon, M.D.				ADDRESS Hagerstown, Md. 21740															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 16, 79				23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn				23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash. Md.							
24. FUNERAL DIRECTOR NAME Thompson Funeral Home								25a. DATE RECEIVED BY REGISTRAR JUL 19 1979								25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR			7 9 1 8 3 6 7 REG. NO.								
1 DECEASED NAME (TYPE OR PRINT)			FIRST Irene R.			MIDDLE Hebb			LAST		
2a DATE OF DEATH			MONTH 7			DAY 16			YEAR 1979		
2b HOUR			348			PM					
3 SEX female			4 RACE Cau			5 DATE OF BIRTH MONTH DAY YEAR August 18, 1909			6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown			11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) office			12b KIND OF BUSINESS OR INDUSTRY shoe mfg.		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Washington			13c CITY OR TOWN Hagerstown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET ADDRESS 1016 Oak Hill Avenue			14 FATHER'S NAME FIRST MIDDLE LAST Edward Ridenour			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Bloom					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-5406			17 INFORMANT ADDRESS William R. Hebb, Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION None			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>7/8</u> , 19 <u>79</u> , to <u>7/16</u> , 19 <u>79</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>7/16</u> , 19 <u>79</u> , and that in <u>my</u> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.											
22b SIGNATURE <u>Richard E. Smith, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 7/16/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.						22e ADDRESS 1708 Oak Hill Ave., Hagerstown, Md					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE July 17, 1979			23c NAME OF CEMETERY OR CREMATORY Rosedale Funeral Home			23d LOCATION CITY OR TOWN COUNTY STATE Martinsburg, Berkeley, W. Va.		
24 FUNERAL DIRECTOR NAME Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740						25a DATE RECEIVED BY REGISTRAR JUL 19 1979			25b REMARKS <u>buried in cemetery</u>		

1828

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 8 3 6 8

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE Russell		LAST Hors Ham		2b. DATE KNOWN OF DEATH ESTI- MATED		MONTH July		DAY 27		YEAR 1979		2d. HOUR 3p M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR April 9, 1946		6. AGE (IN YEARS) LAST BIRTHDAY 33 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD		MONTH July		DAY 27		YEAR 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD											
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 306 Radcliffe Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Airforce				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland				13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 306 Radcliffe Avenue							
14. FATHER'S NAME FIRST MIDDLE LAST William Horsham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Strite													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam		17. INFORMANT ADDRESS Mr. William Horsham, Hagerstown, Md											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>E965 SUICIDE by Fire Arms thru Head</u> 9554 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sc 24h																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 P.M. July 27 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted gun shot Thru Head									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 306 Radcliffe Hagerstown Wash MD									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE H. N. Weeks				TITLE (SPECIFY) Dep. MEDICAL EXAMINER				DATE SIGNED July 27 '79									
EXAMINER'S NAME (TYPE OR PRINT) H. N. Weeks				ADDRESS 580 Northern Ave Hagerstown, Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 30, 1979		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland							
24. FUNERAL DIRECTOR NAME Minnich Funeral Home				ADDRESS 415 E. Wilson Blvd. Hagerstown, Maryland 21740				25a. DATE REC'D. BY REGISTRAR AUG 01 1979				25b. REGISTRAR'S SIGNATURE Dorothy McBrady					

8 0 0 8 1

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NEWARK, N. J. 10/10/1918

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Grace Elizabeth Huffer			2a. DATE OF DEATH MONTH DAY YEAR July 31, 1979			2b. HOUR P M 3:20 P M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 4, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farming		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Rohrersville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 66, Rt. 1	
14. FATHER'S NAME FIRST MIDDLE LAST Maurice Zecker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Bealer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 34 1012D		17. INFORMANT ADDRESS Betty J. Violet, Box 354, Rohrersville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> <u>1541</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left hydrothorax due to metastatic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Carcinoma of the Rectum</u> DUE TO, OR AS A CONSEQUENCE OF in the lungs May 1979 Nov. 1977								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 18</u> , 19 <u>79</u> , to <u>July 31</u> , 19 <u>79</u> , that (1) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>July 31</u> , 19 <u>79</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (1) <input checked="" type="checkbox"/> did (d) <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE <u>Fe U. Porciuncula</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <u>July 31, 1979</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M.D.						22e. ADDRESS 1500 Pennsylvania Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-3-79		23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Locust Grove, Wash. Co., Md.			
24. FUNERAL DIRECTOR NAME John H. Bast, Jr.						ADDRESS Boonsboro, Md. 21713		25a. DATE REC'D. BY REGISTRAR AUG 6 1979		
						25b. REGISTRAR'S SIGNATURE <u>Patty McBurney</u>				

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1203 BP _____
DHMH - 17
(VR A15 ME (5))
15M7/77



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8370

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED		2c. MONTH		2d. DAY		2e. YEAR		2f. HOUR	
Evangeline		Johnson						July 26 1979		4:00 PM									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. MONTH		11. DAY		12. YEAR	
Female		Black		Aug 2, 1970		8 YRS		MONTHS		DAYS		HOURS		MIN.		July 26		1979	
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		14. CITIZEN OF WHAT COUNTRY?		15. MARRIED		16. NEVER MARRIED		17. WIDOWED		18. DIVORCED		19. BALTIMORE CITY OR COUNTY OF DEATH		20. CITY OR TOWN OF DEATH		21. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		22. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore, Md		U.S.A.		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		Washington County		Md.		Washington County Hospital		Student	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. INSIDE CITY LIMITS?		13g. STREET ADDRESS		13h. INSIDE CITY LIMITS?		13i. STREET ADDRESS		13j. INSIDE CITY LIMITS?	
Md.		Baltimore		Baltimore		YES		2441 Barclay St		YES		2441 Barclay St		YES		2441 Barclay St		YES	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. DATE		21. CITY OR TOWN		22. COUNTY		23. STATE	
James		Evelyn		NO		X		2441 Barclay St		Baltimore		Md		Md		Md		Md	
14a. FIRST		14b. MIDDLE		14c. LAST		15a. FIRST		15b. MIDDLE		15c. LAST		16a. YES		16b. NO		17a. YES		17b. NO	
James		Gauling		Gauling		Evelyn		Gauling		Gauling		YES		NO		YES		NO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. (b)		22. DUE TO, OR AS A CONSEQUENCE OF		23. (c)		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		25. HRS		26. MIN		27. SEC	
430 -		442 - Ruptured berry aneurysm		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		HRS		MIN		SEC			
28. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		29. DATE OF OPERATION		30. CONDITION FOR WHICH OPERATION WAS PERFORMED?		31. AUTOPSY?		32. YES		33. NO		34. DATE		35. CITY OR TOWN		36. COUNTY		37. STATE	
28a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		28b. TIME OF INJURY		28c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		29a. DATE OF OPERATION		29b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		29c. AUTOPSY?		30a. YES		30b. NO		31a. DATE		31b. CITY OR TOWN	
28d. INJURY OCCURRED		28e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		28f. LOCATION		29a. DATE OF OPERATION		29b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		29c. AUTOPSY?		30a. YES		30b. NO		31a. DATE		31b. CITY OR TOWN	
28g. WHILE AT WORK		28h. NOT WHILE AT WORK		28i. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		28j. LOCATION		29a. DATE OF OPERATION		29b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		29c. AUTOPSY?		30a. YES		30b. NO		31a. DATE	
28k. I certify that I took charge of the remains described above, held on		28l. Autopsy		28m. Inspection		28n. Inquiry		28o. and in my opinion		28p. death resulted from:		28q. Natural Causes		28r. Accident		28s. Suicide		28t. Homicide	
28u. Actual Signature		28v. TITLE (SPECIFY)		28w. MEDICAL EXAMINER		28x. DATE SIGNED		28y. July 27, 1979		28z. ADDRESS		28aa. 580 Northern Ave. Hagers. MD		28ab. BALTIMORE CITY		28ac. COUNTY		28ad. STATE	
28ae. EXAMINER'S NAME (TYPE OR PRINT)		28af. HOWARD N. WEEKS, M.D.P.A.		28ag. ADDRESS		28ah. 580 Northern Ave. Hagers. MD		28ai. BALTIMORE CITY		28aj. COUNTY		28ak. STATE		28al. DATE REC'D BY REGISTRAR		28am. JUL 30 1979		28an. REGISTRAR'S SIGNATURE	
28ao. BURIAL, CREMATION, REMOVAL (SPECIFY)		28ap. DATE		28aq. NAME OF CEMETERY OR CREMATORY		28ar. LOCATION		28as. CITY OR TOWN		28at. COUNTY		28au. STATE		28av. NAME		28aw. ADDRESS		28ax. DATE REC'D BY REGISTRAR	
Burial		8/31/79		Baltimore Cemetery		Baltimore City		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore		Baltimore	
28ay. FUNERAL DIRECTOR		28az. NAME		28ba. ADDRESS		28bb. DATE REC'D BY REGISTRAR		28bc. REGISTRAR'S SIGNATURE		28bd. NAME		28be. ADDRESS		28bf. DATE REC'D BY REGISTRAR		28bg. REGISTRAR'S SIGNATURE		28bh. NAME	
Baltimore		Baltimore		Baltimore		JUL 30 1979		Baltimore		Baltimore		Baltimore		JUL 30 1979		Baltimore		Baltimore	

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Handwritten signature or initials.

100-20-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 8 3 7 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) ALONZA NMN JONES					2a. DATE OF DEATH MONTH DAY YEAR HOUR JULY 15 1979 11:51 A.M.				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 9, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Tender		12b. KIND OF BUSINESS OR INDUSTRY Paper	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Penna. 13b. COUNTY Franklin 13c. CITY OR TOWN Chambersburg					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 221 North Hackberry Dr.		
14 FATHER'S NAME FIRST MIDDLE LAST Frank Jones					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Crider				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 175-03-3832		17 INFORMANT ADDRESS Mrs. H. Jones 221 N. Hackberry Dr. Pa. 17201					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 431- DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ANEURYSM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7-4 , 19 79 , to 7-15 , 19 79 , that we (we) last saw the deceased alive on 7-15 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (we) did not view the body after death, _____)									
22b. SIGNATURE Edward Byrd M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 7-15-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD Byrd M.D.					22e. ADDRESS 1190 Mt. Aetna Rd. Hagerstown Pa. 17201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/18/1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Franklin Pa.			
24. FUNERAL DIRECTOR NAME John O. Park					ADDRESS 152 S. 2nd St. Chambersburg Pa. 17201		25a. DATE REC'D. BY REGISTRAR JUL 18 1979		25b. REGISTRAR'S SIGNATURE Henry McHenry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		7 9 1 8 3 7 2	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3. HOUR	
Lucille Myrtle Kennedy		July 4th 1979		3:45pm	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	January 6, 1909	70	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.		Washington County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown	Washington County Hospital	Victor Prod.	Vend. Mach.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	921 E. Lanvale Street	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
William	Lankford	Lula Carrie Lankford			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS			
No	212-14-6645	Delores V. Hessong, 42 N. Cannon Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY					APPROXIMATE INTERVAL BETWEEN DEATH AND EXAMINATION
IMMEDIATE CAUSE (a) Pneumonia					2 days
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Disease					10 years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Cerebrovascular Accident					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from July 4, 1979 to July 4, 1979, that (1) I saw the deceased alive on (above) (we) and (did not) view the body after death.					
22b. SIGNATURE Robert Buell		22c. DATE SIGNED 7/4/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Buell		22e. ADDRESS 138 E. Antietam St. Hagerstown			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	7-7-79	Rest Haven Cemetery	Hagerstown, Wash., Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Rest Haven Funeral Chapel, Inc., Hag.,		MAY 9 1979		[Signature]	

Lucile M. White
July 1914
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Provisional
Census District in Long House 10 years

Constitutional Amendment

Robert Powell
July 1914
10 2 1 2
✓
July 1914
10 2 1 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 1 8 3 7 3	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Joseph Woodrow KITTELL, SR.				2a. DATE OF DEATH July 15, 1979		2b. HOUR 9A ^M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH March 5, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 66		7. IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital D.O.A.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) service		12b. KIND OF BUSINESS OR INDUSTRY gas Co.			
13a. STATE Maryland		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 1821 Heisterboro Road					
14. FATHER'S NAME Bruce R. Kittell		15. MOTHER'S MAIDEN NAME Minnie V. Boward		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. W.W.II 214-09-3103		17. INFORMANT ADDRESS Mrs. Louise Kittell, Hagerstown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Obstructive Pulmonary Disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1978</u> to <u>July 15, 1979</u> , that (I) (we) lost saw the deceased alive on <u>July 15, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) <u>view the body after death.</u>											
22b. SIGNATURE <u> Sidney E. Novenstein</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7/16/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>SIDNEY NOVENSTEIN</u>		22e. ADDRESS <u>FUNKSTOWN MD</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 18, 1979		23c. NAME OF CEMETERY OR CREMATORY Beaver Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Peaver Creek, Wash., Maryland					
24. FUNERAL DIRECTOR NAME <u>Minnich Funeral Home</u> 415 East Wilson Blvd., Hagerstown, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 19 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

1878



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 8 3 7 4		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Merle Richard Kline				2a. DATE OF DEATH MONTH DAY YEAR 7 31 79		2b. HOUR 5:13 P			
3 SEX Male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR October 23, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wolfsville, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b. KIND OF BUSINESS OR INDUSTRY Pangborn	
13a. STATE Md.				13b. COUNTY Wash.		13c. CITY OR TOWN Cavetown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS Box 142				14 FATHER'S NAME FIRST MIDDLE LAST Paul Kline Sr.		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Mae Kuhn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-12-1810		17 INFORMANT ADDRESS Mrs. Mary E. Kline Cavetown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic Cardiovascular Disease 10 yrs DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-5 1962 to 7-31 1979, that (I) (we) lost saw the deceased alive on 7-31 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Charles F. Hess M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-1-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles F. Hess M.D.				22e. ADDRESS Smithsburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 3, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Lutheran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wolfsville, Frederick Md.			
24 FUNERAL DIRECTOR NAME Davis Funeral Home				25a. DATE RECEIVED BY REGISTRAR AUG 6 1979		25b. REGISTRAR'S SIGNATURE AUGUST 6 1979			

MEDICAL CERTIFICATION

18374



18374

18374

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR		REG. NO. 18375								
1 DECEASED NAME (TYPE OR PRINT) George Edward Klipp					2a DATE OF DEATH MONTH 7 DAY 14 YEAR 79					2b HOUR 10:20 PM
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH May DAY 24 YEAR 1911		6 AGE (IN YEARS LAST BIRTHDAY) 68		7 IF UNDER 1 YEAR MONTHS YRS DAYS YRS HOURS MIN.		
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer		12b KIND OF BUSINESS OR INDUSTRY W.D. Byron		
13a STATE Maryland					13b COUNTY Washington		13c CITY OR TOWN Williamsport		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST George MIDDLE Klipp LAST Klipp					15 MOTHER'S MAIDEN NAME FIRST Grace MIDDLE -- LAST --					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 214-16-0441		17 INFORMANT ADDRESS Jeanne E. House P.O. Box 306 Wmspt., MD 21795						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) severe pulmonary obstructive disease yrs DUE TO, OR AS A CONSEQUENCE OF (c) Chronic bronchitis and emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (the) hospital attended the deceased from 7/14 19 79 , to 7/14 19 79 , that (I) (we) lost saw the deceased alive on 7/14 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do not) view the body after death.										
22b SIGNATURE Thomas V. Craig		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c DATE SIGNED 7/14/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 239 N. Potomac Hagerstown, Md. 21740								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE July 19, 1979		23c NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD		23e DATE REC'D. BY REGISTRAR		
24 FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 348 Wmspt., MD		24b ADDRESS		24c DATE REC'D. BY REGISTRAR 11/11 23 1979		24d REGISTRAR'S SIGNATURE Pinkney, Ann P. Road				

1872



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 8 3 7 6 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Myrtle Anita Knott					2a. DATE OF DEATH MONTH DAY YEAR July 4, 1979			2b. HOUR 4:10 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Atlanta, Ga.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home		
13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - - Hodge					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie - - Murphy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 30 9378A		17. INFORMANT ADDRESS 900 View St. Joseph E. Knott, Jr. Hagerstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Rt Hemiparesis 4 days 4340 } DUE TO, OR AS A CONSEQUENCE OF b) Generalised Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease, Diabetes										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from June 30, 1979, to July 4, 1979, that (I) (we) lost saw the deceased on July 4, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE Robert V. Campbell MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/30/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert V. H. Campbell					22e. ADDRESS Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-7-79		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Maryland			
24. FUNERAL DIRECTOR NAME Gerald N. Minnich		ADDRESS 305 N. Potomac St. Hagerstown, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 3 1979		25b. REGISTRAR'S SIGNATURE Hickey McCreedy			

BP

1837

July 4, 1837

Dear Sir

Received

of the sum of \$100

for the sum of \$100

for the sum of \$100

for the sum of \$100

for the sum of \$100

for the sum of \$100

for the sum of \$100

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for the sum of \$100

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 3 7 7

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLARA ELIZABETH LAKIN		2a. DATE OF DEATH MONTH DAY YEAR 7 5 79		2b. HOUR 5³⁰ P.M.
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-5-1912		6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary	12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Moller Apts.
14. FATHER'S NAME FIRST MIDDLE LAST Lindsie - Fuller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl E. Neff		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) A705 14 0242		17. INFORMANT ADDRESS 209 Mysticwood Rd. Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatous involving liver, bones brain 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma left breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 18 months		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION JAN 1978	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA LEFT BREAST	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/28 19 79 to 7/5 19 79 , that (I) (we) lost saw the deceased alive on 7/5 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE John R. Marsh, M.D.		DEGREE M.D.	22c. DATE SIGNED 7/6/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN R. MARSH, M.D.		22e. ADDRESS 239 N. POTOMAC ST. HAGERSTOWN, MD 21740	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-7-79	23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery Shippensburg, Penna.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland		25a. DATE RECEIVED BY REGISTRAR JUL 12 1979	25b. REGISTRAR'S SIGNATURE John R. Marsh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1877



Washington, D.C.
February 1877
The Secretary of the Interior
Department of the Interior
Washington, D.C.

Received of the Secretary of the Interior
the sum of \$100.00
for the purchase of land
in the State of California
for the purpose of
establishing a national monument
in the State of California
for the purpose of
preserving the natural
scenery and objects of
interest therein

Witness my hand and the seal of the Department of the Interior
this 18th day of February 1877
at Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					7 9 1 8 3 7 8 REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Pauline Viola Larkin					2a DATE OF DEATH MONTH DAY YEAR July 14, 1979			2b HOUR M		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1937		6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress		12b KIND OF BUSINESS OR INDUSTRY rain coat Co.		
13a STATE Maryland			13b COUNTY Washington		13c CITY OR TOWN Boonsboro		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 1, Box 31	
14 FATHER'S NAME FIRST MIDDLE LAST Boyd Eugen Kaiser					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Mary Jones					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 209-28-8119		17 INFORMANT ADDRESS Mr. Kenneth W. Larkin, Boonsboro, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Metastases</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>mos.</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>79</u> , to <u>14 July</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>14 July</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we do not) view the body after death.										
22b SIGNATURE <u>J. D. Wilson</u>					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>7/14/79</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson, M.D.					22e ADDRESS 580 Northern Avenue, Hagerstown, Maryland					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE July 17, 1979		23c NAME OF CEMETERY OR CREMATORY Manor Church Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Tilgmanston, Wash., Maryland			
24 FUNERAL DIRECTOR NAME Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland					25a DATE REC'D BY REGISTRAR JUL 19 1979		25b REGISTRAR'S SIGNATURE <u>Robert McHenry</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frank Marburg LIAS			2a. DATE OF DEATH MONTH DAY YEAR 7 28 1979			2b. HOUR 11:45 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 30, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 124 Broadway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) pattern maker	
						12b. KIND OF BUSINESS OR INDUSTRY sign Co.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 124 Broadway		
14. FATHER'S NAME FIRST MIDDLE LAST George Lias			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bachtel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-14-6833		17. INFORMANT Mrs. Elsie M. Lias, Hagerstown, Maryland			ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENEROUS CARCINOMATOSIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF <u>CARCINOMA of COLON</u> 5 12 1978	
		DUE TO, OR AS A CONSEQUENCE OF	
		(c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-27-79</u> 19 <u>79</u> to <u>7-28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7-27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>MD</u>		22c. DATE SIGNED 7-28-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>OTTO ROZA MD</u>				22e. ADDRESS <u>100 LONG MEADOW DRIVE HAGERSTOWN MD</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 1, 1979		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland	
24. FUNERAL DIRECTOR NAME Minnich Funeral Home 415 East Wilson Blvd., Hag. Maryland 21740				25a. DATE REC'D. BY REGISTRAR AUG 1 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 8 3 8 0	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Martin, Ernest William Sr.					2a. DATE OF DEATH MONTH DAY YEAR 7-11-79			2b. HOUR 1P			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 14, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) owner		12b. KIND OF BUSINESS OR SERVICE & EMPLOYMENT floor & wall service & employ trucking co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 67 Manor Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest V. Martin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada V. Postetter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1945		17. INFORMANT Edith A. Martin, Hagerstown, Md.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with Right Hemiplegia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Sudden Myocardial Infarction, Moderate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2500 4 days 2-3 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Hypertension and Coronary Heart Disease											
19a. DATE OF OPERATION 7/8/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Coronary Artery Bypass				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (the hospital) attended the deceased from 8 July 1979 to 11 July 1979 , that (we) last saw the deceased alive on 11 July 1979 and that in (our) opinion death occurred on the date and hour and from the causes stated above; (b) (we) (did not) view the body after death.											
22b. SIGNATURE Wm. W. White, M.D.					DEGREE M.D.		22c. DATE SIGNED 7-11-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR NAME 415 E. Wilson Blvd., Hagerstown, Md. 21740					25a. DATE REC'D. BY REGISTRAR JUL 13 1979		25b. REGISTRAR'S SIGNATURE Pietro McCreedy				



Item 8 G 533 7/30/79 GB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 3 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rhoda E. Martin			2a. DATE OF DEATH MONTH DAY YEAR July 13, 1979		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 17, 1883		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.	
10. CITY OR TOWN OF DEATH Maugansville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 215 S. North Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Washington	13c. CITY OR TOWN Maugansville	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Miss Garnette Martin, 215 S. North St	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Thrombosis</u> (c) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MIN</u> <u>MIN</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 79, 1979 to July 13, 1979, that (I) (we) last saw the deceased alive on June 79, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE J. D. Wilson, M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/13/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson, M.D.			22e. ADDRESS 580 Northern Ave., Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-16-79		23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery Hagerstown, Wash., Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR Md. JUL 18 1979			
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag., Md.		25a. DATE REC'D. BY REGISTRAR Md. JUL 18 1979			
25b. REGISTRAR'S SIGNATURE R. H. Hager					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 8 3 8 2 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Nina Marie Mason						2a. DATE OF DEATH MONTH DAY YEAR 7-23-79		2b. HOUR 1202 M	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 8-6-1906		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. 1958		12b. KIND OF BUSINESS OR INDUSTRY Fed. Silk Mill	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 101 Wakefield Road	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Clayton Mentzer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Rebecca Stenger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-05-2945		17. INFORMANT Roger A. Mason			ADDRESS (item 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerotic heart disease</u> years DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>post operative cholecystectomy</u>									
19a. DATE OF OPERATION 7-19-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gallstones				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7-18-79</u> , 19____, to <u>7-23-79</u> , 19____, that (I) (we) lost saw the deceased alive on <u>7-23-79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>E. Hawbaker M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-23-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Hawbaker, M.D.				22e. ADDRESS 645 E. 1st St., Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 7/26/79		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD			
24. FUNERAL DIRECTOR Osborne Funeral Home P.O. Box 348 Wmspt., MD				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 30 1979 <u>[Signature]</u>					

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Figure 1

Journal of Management Inquiry 22(1)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

18383

1 DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MARY C. MIDDLE C. LAST Mathes			7/6/79			M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		
Female		White		11-11-1912		66		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
New York		USA				Washington MD.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Hagerstown		Washington Co. Hospital				housewife		home
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland			Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET ADDRESS		
FIRST MIDDLE LAST Michael - - Freeman			FIRST MIDDLE LAST Margaret - - Murphy			2241 Fairfax Road		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
no					Alexander Mathes see # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) 5321 CARDIO RESPIRATORY ARREST -								
DUE TO, OR AS A CONSEQUENCE OF (b) STRESS								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (c) PERSONATED duodenal ulcer								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/23/79, 1979, to 7/6/79, 1979, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE C. D. WOOSTER						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/6/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. D. WOOSTER						22e ADDRESS 1825 Howell Rd HAGERSTOWN		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			7-9-79		Rest Haven Cemetery		Hagerstown, Maryland	
24. FUNERAL DIRECTOR NAME			305 N. Potomac St. Hagerstown, Maryland			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Gerald N. Minnich						JUL 12 1979 history McCreedy		

BP



6 6 8 1 7 1

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 3 8 4

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Gertrude Willamina Mathews			2a DATE OF DEATH MONTH DAY YEAR July 27, 1979		2b HOUR 3:00 A M
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR April 15, 1888		6 AGE (IN YEARS LAST BIRTHDAY) 91 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
10 CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 9406 Monroe St., Silver Spring
14 FATHER'S NAME FIRST MIDDLE LAST John A. Sangran		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 577 32 2286		17 INFORMANT ADDRESS Walter R. Mathews, 9406 Monroe St., SS, Md.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory failure 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia, congestive failure (c) Generalized arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) Carcinoma of the rectum					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from Feb. 6, 1979 to July 27, 1979 , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on July 27, 1979 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.					
22b SIGNATURE Fe U. Porciuncula		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/27/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fe U. Porciuncula, M.D.		22e ADDRESS 1500 Pennsylvania Ave., Hagerstown, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-31-79		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, Va.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
24 FUNERAL DIRECTOR NAME ADDRESS Rest Haven Funeral Chapel, Inc., Hag., Md.		25a. DATE REC'D. BY REGISTRAR AUG 3 1979			
		25b. REGISTRAR'S SIGNATURE <i>Patricia A. Bailey</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1873



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 8 3 8 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE LENORE MAZINGO										2a. DATE OF DEATH MONTH DAY YEAR JULY 26, 1979		2b. HOUR 10¹⁵/A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 30, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.							
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEANSTRESS		12b. KIND OF BUSINESS OR INDUSTRY CLOTHING					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY WASHINGTON 13c. CITY OR TOWN HANCOCK										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ROUTE #1	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM NMN CUBBAGE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA NMN BARTON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212 24 85658		17. INFORMANT JAMES J. MAZINGO		ADDRESS SAME AS 13							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT, EMBOLIC 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC HEART DISEASE WITH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF CHRONIC ATRIAL FIBRILLATION (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, UNCONTROLLED													
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from JULY 22 , 19 79 , to JULY 26 , 19 79 , that (1) (we) lost saw the deceased alive on JULY 26 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) did not view the body after death.													
22b. SIGNATURE BARRY M. COHEN				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-26-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN				22e. ADDRESS 138 E. ANTIETAM ST HAGERSTOWN, MD, 21740									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/30/1979		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET PRESBYTERIAN HANCOCK		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, MD.							
24. FUNERAL DIRECTOR NAME Richard S. Grove				ADDRESS HANCOCK MD.		25a. DATE REC'D. BY REGISTRAR AUG 6 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

BP

1-8-82



CELEBRATING THE 100TH BIRTHDAY

OF THE UNITED STATES OF AMERICA

THE PRESIDENT AND VICE PRESIDENT

AND

THE SENATE AND HOUSE OF REPRESENTATIVES

1982

THE WHITE HOUSE

WASHINGTON, D.C.

1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE													
1. FOR STATE REGISTRAR				7 9 1 8 3 8 6 CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Phoebe Brenice McKEE				July 18, 1979								M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
female		white		February 14, 1890		89 YRS		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Washington MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Washington County Hospital											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1002 Bramley Court					
Maryland		Washington		Hagerstown									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
George Baker				Agnes Koontz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS			
NO				216-30-3544		Madeline Gelwicks, Hagerstown, Maryland							
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>													
5570 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
Bowel Infarction - Shock -													
DUE TO, OR AS A CONSEQUENCE OF													
Renal Insufficiency -													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET				CITY OR TOWN		COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.													
22a. SIGNATURE				DEGREE				22c. DATE SIGNED					
C. D. Wilson				MD									
22b. PHYSICIAN'S NAME (TYPE OR PRINT)				22d. ADDRESS									
C. D. Wilson				1825 Howell Rd HDB. MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
burial				July 20, 1979		Rose Hill Cemetery		Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740				JUL 24 1979				R. J. Calbreath					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

 DHMH-17
 (VR A15 ME (5))
 30M 7/73

1. FOR Items 18a&22a		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		1 8 3 8 7	
1- STATE REGISTRAR		9724/7						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR	
Truman Vernon Mencer Jr.				7-16-79				0245	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.	
Male		Cauc.		4-20-22		57 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED	
West Virginia				U.S.A.				WIDOWED	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Hagerstown				Washington County Hospital				Laborer	
13a. STATE				13b. COUNTY				13c. CITY OR TOWN	
Maryland				Washington				Hagerstown	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. SOCIAL SECURITY NO.	
Truman Vernon Mencer				Unknown				236-28-7440	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				17. INFORMANT				18. CAUSE OF DEATH	
Yes				Marie A. Titus				888- Pending Lacerations and Contusions, Live	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED	
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				0230 P.M. 7-16-79				fall on side walk	
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				street				Franklin and Prospect St, Hagerstown, Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED	
E. Hawbaker				Dep.				7-16-79	
EXAMINER'S NAME				ADDRESS				23a. BURIAL, CREMATION, REMOVAL	
E. Hawbaker, M.D.				645 E 1st St, Hagerstown, Md. 21740				Burial	
23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
7-18-79				Rose Hill Cemetery				Hagerstown, Washington, Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
A.K. Coffman Funeral Home, Inc. Hagerstown, Md.				JUL 20 1979				Pinkney McCready	

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 8 3 8 8

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARIE JACEY MILLEN			2a. DATE OF DEATH MONTH DAY YEAR JULY 9, 1979			2b. HOUR 6³⁰/AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 16, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.				
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY WASH		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT 2, Box 349	
14. FATHER'S NAME FIRST MIDDLE LAST John Thomas Light			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Pfeiffer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Doris Spalding		ADDRESS 352 South Potomac Street Hagerstown, Md.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF BREAST DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 7 MONTHS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): NONE										
19a. DATE OF OPERATION 6-20-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PELVIC LAPAROTOMY & EXCISION OF MASS				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from DECEMBER , 19 78 , to JULY 9 , 19 79 , that (1) (we) last saw the deceased alive on JULY 8 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) (did) (did not) view the body after death.										
22b. SIGNATURE Barry M. Cohen		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7-9-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY M. COHEN				22e. ADDRESS 138 E. ANTISTAM ST HAGERSTOWN, MD, 21740						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-11-79		23c. NAME OF CEMETERY OR CREMATORY Woodbine Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Harrisonburg, Rockingham Va.				
24. FUNERAL DIRECTOR NAME ADDRESS A.K. Coffman Funeral Home, Inc. Hagerstown, Md.				25a. DATE REC'D BY REGISTRAR JUL 11 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use as the burial transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Female white August 10, 1895

Virginia U.S.A.

Washington County Hospital Harrisonville

John Thomas 11 1/2 months

150 South Second Street
Harrisonville, Mo.

1-1-10
Harrisonville, Mo.
Washington County Hospital
Harrisonville, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 8 3 8 9 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY CATHERINE MILLER						2a. DATE OF DEATH MONTH DAY YEAR 7/11/79		2b. HOUR 5:10 A.M.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR July 5 1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON COUNTY MD.			
10 CITY OR TOWN OF DEATH WILLIAMSPORT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOMWOOD RETIREMENT CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY Howard		13c. CITY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3137 The Oak Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST ROBERT McGINN				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA HAYDEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-46-4310		17 INFORMANT C. I. DeGrange		ADDRESS 2750 Virginia Avenue Williamsport, Md. 21795			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arterio Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Organic Brain Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/20 1974 to 7/11 1979, that (I) (we) last saw the deceased alive on 7/7 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sidney Novenstein				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/11/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SIDNEY NOVENSTEIN				22e. ADDRESS FUNKSTOWN					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/79		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cen.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Witzke Catonsville Funeral Home, P.A. 21228				25a. DATE REC'D. BY REGISTRAR JUL 16 1979		25b. REGISTRAR'S SIGNATURE Sidney Novenstein			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 18390																			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR 7 21 79						2b. HOUR 437 P.M.																	
1. DECEASED NAME (TYPE OR PRINT) Clytie Forrest Mills						3 SEX F						4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR April 14 1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland						7b. CITIZEN OF WHAT COUNTRY? U.S.A.						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.											
10. CITY OR TOWN OF DEATH Hagerstown						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife						12b. KIND OF BUSINESS OR INDUSTRY Home											
13a. STATE Maryland						13b. COUNTY Washington						13c. CITY OR TOWN Williamsport						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 102 E. Church St.					
14. FATHER'S NAME FIRST MIDDLE LAST Ridgeley Hamilton Renner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Virginia DeLouney						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 220-16-0003						17. INFORMANT Dorothea McCardell 11 N. Conococheague St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiorespiratory Arrest																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
1629																													
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma of Lung																		x6 months											
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Frederic A. Kass III MD																		DEGREE				22c. DATE SIGNED 7/21/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass III																		22e. ADDRESS 1825-1 Howell Rd, Hagerstown MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial						23b. DATE 7/25/79						23c. NAME OF CEMETERY OR CREMATORY Greenlawn Mem. Park						23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington MD											
24. FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. Box 348 Wmspt. MD																		25a. DATE REC'D BY REGISTRAR JUL 30 1979				25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7. 9 18391 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Clarence Minnick					2a. DATE OF DEATH MONTH DAY YEAR July 6 1979			2b. HOUR M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 15, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Funkstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 102 West Green Street	
14 FATHER'S NAME FIRST MIDDLE LAST Walter Minnick					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Bryson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-6375		17 INFORMANT ADDRESS Mr. Leon Minnick, Williamsport, Maryland					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatous</u> 1990 DUE TO, OR AS A CONSEQUENCE OF (b) <u>of spine involvement 6 mo t.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease, Atrial fibrillation</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3 Feb 59</u> to <u>late</u> , that (I) (we) last saw the deceased alive on <u>5 July 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.									
22b. SIGNATURE Richard T. Bradford MD					22c. DEGREE MD			22d. DATE SIGNED 6/8/79	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard T. Bradford					22f. ADDRESS Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 9, 1979		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland			
24 FUNERAL DIRECTOR'S NAME Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland					25a. DATE REC'D. BY REGISTRAR JUL 12 1979				
					25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

1981



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 8 3 9 2

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Clyde Moler			2a. DATE OF DEATH MONTH July DAY 7 YEAR 1979			2b. HOUR 11:20 MIN. PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH October DAY 6 YEAR 1890		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County, MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Potomac Edison		12b. KIND OF BUSINESS OR INDUSTRY Electric		
13a. STATE Maryland			13b. CITY OR TOWN Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 228 E. Irvin Avenue	
14. FATHER'S NAME FIRST Charles MIDDLE Brook LAST Moler			15. MOTHER'S MAIDEN NAME FIRST Ella MIDDLE Beard LAST Anderson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-10-9043		17. INFORMANT ADDRESS Lydia A. Moler, 228 E. Irvin Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Carcinoma of right lung. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos +		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Arteriosclerotic Cardio. Dis.; Pneumonia; Depression.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Hagerstown, Wash. Md.					
22a. I certify that (I) (this hospital) attended the deceased from 7 July 1979 to 7 July 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (a) (b) (c) (did) (did not) view the body after death.										
22b. SIGNATURE Richard T. Bixford			22c. DEGREE MD.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED JUL 11 1979		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-11-79		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Md.			
24. FUNERAL DIRECTOR NAME Rest Haven Funeral Chapel, Inc., Hag.			ADDRESS Md.			25a. DATE REC'D. BY REGISTRAR JUL 11 1979				

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Charles C. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO. 7 9 1 8 3 9 3										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
Bernard Lee MONGAN			July 29, 1979								M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
male		white		September 17, 1918		60 YRS		MONTHS		DAYS		HOURS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH		12. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		13. MONTHS		MIN.	
West Virginia		USA				Washington						MD.	
14. CITY OR TOWN OF DEATH		15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		17. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Route 2		plumber & pipe fitter									
18a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		18b. COUNTY		18c. CITY OR TOWN		19. INSIDE CITY LIMITS?		20. STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 2, Box 128					
21. FATHER'S NAME		22. MOTHER'S MAIDEN NAME		23. INFORMANT		24. ADDRESS							
William T. Mongan		Carrie M. Long		Mrs. Almata Mae Mongan, Hagerstown, Md.									
25a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		25b. SOCIAL SECURITY NO.		26. DATE OF DEATH		27. MONTH		28. DAY		29. YEAR		30. HOUR	
No		217-12-1538		July 29, 1979								M	
31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY										Moments			
IMMEDIATE CAUSE (a) Cardiac Arrhythmia													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Arteriosclerotic Cardiovascular disease 8 yrs.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
None													
32a. DATE OF OPERATION		32b. CONDITION FOR WHICH OPERATION WAS PERFORMED		32c. AUTOPSY?		32d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
33a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		33b. TIME OF INJURY		33c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
34a. INJURY OCCURRED		34b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34c. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
35a. I certify that (1) (this hospital) attended the deceased from Aug. 11, 1967, to present, 1979, that (1) (we) lost saw the deceased alive on July 9, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not see the body after death.													
36a. SIGNATURE										DEGREE		36b. DATE SIGNED	
Charles C. Spencer, M.D.										MD		7/30/79	
37a. PHYSICIAN'S NAME (TYPE OR PRINT)										37b. ADDRESS			
Charles C. Spencer, M.D.										138 E. Antietam St., Hagerstown, Md.			
38a. BURIAL, CREMATION, REMOVAL (SPECIFY)		38b. DATE		38c. NAME OF CEMETERY OR CREMATORY		38d. LOCATION		CITY OR TOWN		COUNTY		STATE	
burial		August 1, 1979		Rest Haven Cemetery		Hagerstown, Wash., Maryland							
39. FUNERAL DIRECTOR NAME										40. DATE REC'D BY REGISTRAR		41. REGISTRAR'S SIGNATURE	
MINNICH FUNERAL HOME										AUG 6 1979		[Signature]	
42. ADDRESS													
415 E. Wilson Blvd., Hagerstown, Md. 21740													





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		7 9 1 8 3 9 4							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorthy Marie MORENO						2a. DATE OF DEATH MONTH DAY YEAR HOUR June 12, 1979 8A 55 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 12, 1979		6. AGE (IN YEARS LAST BIRTHDAY) YRS 00		7. IF UNDER 1 YEAR MONTHS DAYS 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Washington Hagerstown						13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Ramon Moreno						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lauretta Della Hauff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS KING St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Anencephaly</u> 7400 DUE TO, OR AS A CONSEQUENCE OF (b) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>none</u>									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/12/79 8:43 am</u> to <u>6/12/79 8:45 am</u> (we) lost saw the deceased alive on <u>6/12/79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE OF PHYSICIAN <u>Pierre Asmar</u>						DEGREE <u>M.D.</u>		22c. DATE SIGNED 6/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pierre Asmar, M.D.						22e. ADDRESS Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/22/79		23c. NAME OF CEMETERY OR CREMATORY Washington Co. Hospital		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Wash, Maryland			
24. FUNERAL DIRECTOR NAME <u>Julie G. D.</u>						25a. DATE REC'D. BY REGISTRAR AUGO 3 1979		25b. REGISTRAR'S SIGNATURE <u>John J. Brady</u>	

1838



AMERICAN

1838

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 3 9 5	
1. DECEASED NAME (TYPE OR PRINT) Myers Wilbur Charles FIRST CHARLES MIDDLE WILBUR LAST MYERS						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> July 6 19 79		2b. HOUR 10 ⁴⁵ AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 5 1903		6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD July 6 19 79 10 ²⁵ PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Amer. Optical	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. CITY OR TOWN Frederick		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Buckeystown, Maryland					
14. FATHER'S NAME FIRST MIDDLE LAST Wilbur Beverage Myers						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Rebecca Fry					
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212 03 4753		17. INFORMANT ADDRESS Mrs. Ruth Myers, Buckeystown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>E882 - Fall From Building</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>(Brain injury with Hemorrhage and)</u> (c) <u>(Contusion)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION June 23, 1979				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Brain Injury with Hemorrhage						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. June 22, 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall from Roof of Building					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION CITY OR TOWN COUNTY STATE Buckeystown - Frederick Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Edward W. Ditto III				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 7/6/79			
EXAMINER'S NAME (TYPE OR PRINT) Edward W. Ditto III				ADDRESS 212 W. Wash. St. Hager. Md. 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 10, 1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Frederick Md.			
24. FUNERAL DIRECTOR'S NAME Smith, Radeley, Keeney & Basford						25a. DATE REC'D BY REGISTRAR JUL 13 1979					
106 East Church Street, Frederick, Maryland						25b. REGISTRAR'S SIGNATURE [Signature]					

2928

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 8 3 9 6 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) John Robert Newcomer					2a. DATE OF DEATH 31 July 1979			2b. HOUR 1:20 A.M.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH 10 25 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boilermaker		12b. KIND OF BUSINESS OR INDUSTRY Brewer Plants		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 221	
14. FATHER'S NAME LEWIS STANUP NEWCOMER					15. MOTHER'S MAIDEN NAME MAUDE TICE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown NO			16b. SOCIAL SECURITY NO. 215-01-9921		17. INFORMANT Ada Ruth Newcomer, Rt. 2, Box 221 Williamsport, Md. 21795					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 586- IMMEDIATE CAUSE (a) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>ASCVD recent amputation R leg, COPD</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-29</u> 19 <u>79</u> , to <u>7-31</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edwin G. Riley MD					DEGREE MD			22c. DATE SIGNED 7-31-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin G. Riley MD					22e. ADDRESS 1500 Penna. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG. 2, 1979		23c. NAME OF CEMETERY OR CREMATORY GREENLAWN Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Williamsport Washington Maryland			
24. FUNERAL DIRECTOR NAME MARCEL N. OSBORNE					ADDRESS WILLIAMSPORT, MD.		25a. DATE REC'D. BY REGISTRAR AUG 14 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

0 9 2 8 1 2 3 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7		9		1		8397	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
HOWARD Melvin		PALMER		July 20, 1979		805 AM			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
M		Caucasian		4 - 17 - 03		76 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		USA				Washington MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		COLTON VILLAGE NURSING CENT.		RETIRED					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MARYLAND				BALTIMORE				APT. 6 1027 MAIDEN CHOICE LA.	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
WILLIAM WEBSTER PALMER		NELLIE MEHINA EATON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
NO		214-09-8895		Thomas P. Lamm DA Colton Village					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD 496- DUE TO, OR AS A CONSEQUENCE OF (b) COPD DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5:20, 1979, to 7:30, 1979, that (I) (we) lost saw the deceased alive on 7:50, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Vasant Datta		MD				7.20.79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
VASANT DATTA, M.D.		1600 OAK HILL AVE, HAGERSTOWN, MD 21740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
burial		July 23, 1979		Cedar Lawn Mem. Park		Hagerstown, Wash., Maryland			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home		415 E. Wilson Blvd., Hagerstown, Md. 21740		JUL 24 1979		Rickey McCreedy			

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(M)

25% COTTON FIBER

WILSON

JUL 2 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 9 18398						
1. DECEASED NAME (TYPE OR PRINT) Charles Raymond PENTONEY			2a. DATE OF DEATH MONTH DAY YEAR July 19, 1979				2b. HOUR M		
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1898		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clearview Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) conductor		12b. KIND OF BUSINESS OR INDUSTRY railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Washington 13c. CITY OR TOWN Fairplay			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt Box 47G				
14 FATHER'S NAME FIRST MIDDLE LAST Charles I. Pentoney			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary J. Widemeyer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 705-09-7635		17 INFORMANT ADDRESS Mr. Herbert L. Pentoney, Fairplay, Maryland				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Prostate</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>mos.</u> <u>Years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>May 19 79</u> to <u>19 July 19 79</u> , that (I) (we) lost saw the deceased alive on <u>17 July 19 79</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>J. D. Wilson, MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>7/20/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. D. Wilson			22e. ADDRESS 580 Northern Ave., Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 23, 1979		23c. NAME OF CEMETERY OR CREMATORY Spoors Crossroads Ch.		23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley Spring, W. Va.		
24 FUNERAL DIRECTOR NAME Minnich Funeral Home			24b. ADDRESS 415 E. Wilson Blvd., Hagerstown, Md. 21740			25a. DATE REC'D. BY REGISTRAR JUL 25 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BP _____

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 3 9 9

REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		MONTH DAY YEAR	
Dorothy Eloise		POFFENBERGER		July 25, 1979	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
female	white	Feb. 11, 1915	64	MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Washington		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
Hagerstown	Route 9		housewife		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a CITY OR TOWN	13b INSIDE CITY LIMITS?	13c STREET ADDRESS	
Md. Washington		Hagerstown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Route 9, Box 338	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
Charles F. Brown		Mary G. McKee			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS	
no		218-80-3426		Charles C. Poffenberger, Hagerstown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Metastatic Carcinoma of breast					17 years
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
Frederic H. Kass M.D.		M.D.		7/25/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
Frederic H. Kass M.D.		1825 Howell Rd, Hagerstown Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
burial		July 27, 1979		Beaver Creek Cem.	
				23d LOCATION CITY OR TOWN COUNTY STATE	
				Hagerstown, Md.	
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR	
Minnich Funeral Home		415 E. Wilson Blvd., Hagerstown, Md.		JUL 31 1979	
				25b REGISTRAR'S SIGNATURE	
				[Signature]	

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 8 4 0 0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carl Bernard PRICE				2a. DATE OF DEATH MONTH DAY YEAR 7/ 4/ 79				2b. HOUR 8⁴⁵ A M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR December 10, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer and aircraft fact.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 250 Pangborn Boulevard			
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Price				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Carrier							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-16-1370		17. INFORMANT ADDRESS Mrs. Elsie V. Price, Hagerstown, Md. 21740							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma 2028 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Arteriosclerotic Cardiovascular Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from July , 19 79 , to July 4 , 19 79 , that (1) (we) last saw the deceased alive on 7/13 , 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard E. Smith, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/4/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Smith, M.D.				22e. ADDRESS 1708 Oak Hill Ave. Hagerstown							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 7, 1979		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland					
24. FUNERAL DIRECTOR NAME Minnich Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 9 1979				25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>			
415 E. Wilson Blvd., Hagerstown, Md. 21740											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6 G 534 8/1/79 GB		STATE OF MARYLAND	
FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN IRENE PRICE		2a DATE OF DEATH MONTH DAY YEAR JULY 9 1979 2b HOUR M	
3 SEX female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1898	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	6 AGE (IN YEARS LAST BIRTHDAY) 81 80 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b KIND OF BUSINESS OR INDUSTRY Home		
13a STATE Maryland	13b COUNTY Washington	13c CITY OR TOWN Sharpsburg	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Luther Benner	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Lapole	13e STREET ADDRESS 109 W. Antietam St.	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	16b SOCIAL SECURITY NO. 579-22-7802	17 INFORMANT ADDRESS Martha deVries 109W. Antietam Sharpsburg, MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR THROMBOSIS 4340 } DUE TO, OR AS A CONSEQUENCE OF OLD AND NEW (b) ARTERIOSCLEROSIS (c) DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES MELLITUS. ARTERIOSCLEROTIC HEART DISEASE			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/6, 1969, to 7/9, 1979. I saw the deceased alive on 9/8, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (we) view the body after death.			
22b. SIGNATURE R. Amarillo	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/9/79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. AMARILLO	22e. ADDRESS 127 KING ST HAGERSTOWN MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE July 12, 1979	23c. NAME OF CEMETERY OR CREMATORY Mountain View	23d. LOCATION CITY OR TOWN COUNTY STATE Sharpsburg Washington MD
24 FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. box 348 Wmspt., MD	25a. DATE REC'D. BY REGISTRAR JUL 17 1979	25b. REGISTRAR'S SIGNATURE Lester K. Bandy	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If Item 21 is marked or Item 1B shows any injury, an other traumatic event, the medical examiner must be notified at once.

BP.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 8 4 0 2

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 8 4 0 2			
1 DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		3b. HOUR					
Bertha May Rachor		July 11 1979		6 A					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
Female		White		Jan. 13, 1890		89 YRS		Maryland	
7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
U.S.A.				Washington					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital		Housewife		Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Wash.		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1580 Jefferson Blvd.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
Barrie O. Shank		Barbara Ellen Summer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
no		216-07-8477		Mr. V. Richard Martin, Hagerstown, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		b) Cerebral arteriosclerosis		c) Cerebral arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4340		Cerebral thrombosis & rt. hemiparesis		Cerebral arteriosclerosis		Cerebral arteriosclerosis		2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		yes	
				Arteriosclerotic Cardiac Dis.				yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION ENTER IN PART I (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Disinfectant mellitus; Undernourishment						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART II)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		Hagerstown		Washington Md.	
22a. I certify that (I) (this hospital) attended the deceased from [] to [] that (I) (we) last saw the deceased alive on [] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
[] to []		Richard E. Bradford, M.D.		M.D.		July 14, 1979			
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS							
Richard E. Bradford		Hagerstown, Md.							
24a. BURIAL, CREMATION, REMOVAL (SPECIFY)		24b. DATE		24c. NAME OF CEMETERY OR CREMATOR		24d. LOCATION		COUNTY STATE	
Burial		July 14, 1979		Smithsburg Cemetery		Smithsburg, Wash.		Md.	
25a. FUNERAL DIRECTOR		25b. ADDRESS		25c. DATE OF INTERMENT		25d. REGISTERED STATE			
Davis Funeral Home, Smithsburg, Maryland				July 14, 1979		Maryland			

10181



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]





FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 8 4 0 3

1. DECEASED NAME (TYPE OR PRINT) Lillian NMN Ramsey		2a. DATE OF DEATH MONTH DAY YEAR 22 July 1979		2b. HOUR 7:35 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 10. 1901	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Cibula		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Bobb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 205-01-1694		17. INFORMANT ADDRESS Margaret M. Nicol 826 Forrest Drive Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus DUE TO, OR AS A CONSEQUENCE OF (b) 179- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) OPD, hypopituitarism					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-11 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-11 1979 , to 7-22 1979 , that (I) (we) last saw the deceased alive on 7-22 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edwin G. Riley MD				22c. DATE SIGNED 7-22-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin G. Riley MD				22e. ADDRESS 1500 Penna, Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-28-79		23c. NAME OF CEMETERY OR CREMATORY Westmoreland Co. Mem. Pk Greensburg, Westmoreland, Pa.	
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.		ADDRESS Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR JUL 27 1979	
				25b. REGISTRAR'S SIGNATURE <i>Anthony M. Cuddy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP



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White

Dec. 10, 1961

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Western Maryland Center

2250 Clerk

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 18404

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		12:07P _M	
FIRST MIDDLE LAST		7 15 79			
HARRY CHARLES REESE					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
male	White	MONTH DAY YEAR	43	IF UNDER 24 HRS.	
		10 14 05		MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD Lena	USA		WASHINGTON CTY MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN	WASHINGTON COUNTY HOSPITAL		Farmer		Farming
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
MD	WASHINGTON	HAGERSTOWN	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	405 Guilford Ave	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST			FIRST MIDDLE LAST		
Norman E. Reese			Lizzie Jane Irvin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT		
No		214-09-7001	ADDRESS		
			Mr. Perry F. Reese, Hagerstown, Md. 21740		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio-respiratory arrest					immediate
410- DUE TO, OR AS A CONSEQUENCE OF					
(b) Myocardial infarction					10 days
DUE TO, OR AS A CONSEQUENCE OF					
(c) Arteriosclerotic heart disease					years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
AT WORK					
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1979, to July 15, 1979, that (I) (we) lost saw the deceased alive on July 15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
W S Hood MD				7-15-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
W. S. Hood		Washington County Hospital			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-18-79		Benevola Cemetery	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY STATE	
Benevola, Wash. Co., Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D BY REGISTRAR	
John H. Bast, Jr. Boonsboro, Md. 21713				JUL 18 1979	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

20:25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 7 9 18405									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
FRANK		William		Reid				7 15 79		4 35 PM	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
male		white		January 17, 1917		62 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
W. Virginia		U.S.A.				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Williamsport		Williamsport Nursing Home				Self Employed		Farmer			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS			
W. Virginia		Berkeley		Falling Waters				Rt. 1 Falling Waters, W. Va.			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William Edgar Reid				Vernie Lula Wissinger							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
no		232-26-4312		Lula J. Reid		Rt. 1 Box 71 Falling Waters, W. Va.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amphotrophic Lateral Sclerosis</u> <u>3352</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 25</u> , 19 <u>78</u> , to <u>July 15</u> , 19 <u>79</u> , that (I) (we) lost <u>now</u> the deceased alive on <u>June 28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John R. Melus</u>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/15/79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
burial		July 19, 1979		Harmony Cemetery		Falling Waters Berkeley W. Va.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Osborne Funeral Home P.O. Box 348 Wmspt., Md						JUL 23 1979		<u>Anthony McCreedy</u>			

20187 1A

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

For the purpose of this report, the following information was obtained from the records of the Bureau of Plant Industry, United States Department of Agriculture, Washington, D. C., and from the records of the Bureau of Entomology and Plant Quarantine, United States Department of Agriculture, Washington, D. C.

The following information was obtained from the records of the Bureau of Plant Industry, United States Department of Agriculture, Washington, D. C.

The following information was obtained from the records of the Bureau of Entomology and Plant Quarantine, United States Department of Agriculture, Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79 18406

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HELEN Elizabeth ROBINSON			2a. DATE OF DEATH MONTH JULY DAY 9 YEAR 1979			2b. HOUR 3¹⁵ A M				
3. SEX F		4. RACE CAU		5. DATE OF BIRTH MONTH 1 DAY 18 YEAR 06		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON Co MD.				
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH CO HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) school teacher		12b. KIND OF BUSINESS OR INDUSTRY education		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Pennsylvania			13b. COUNTY Huntingdon		13c. CITY OR TOWN Neelyton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 	
14. FATHER'S NAME FIRST Charles MIDDLE G. LAST Robinson			15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE LAST Fleming							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 178-28-9701		17. INFORMANT Robinson		ADDRESS Alma ROBINSON Neelyton, PA 17239			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA (ORIGIN UNKNOWN) METASTATIC TO BRAIN + OTHER VISCERA 1991 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2+ MONTHS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 										
19a. DATE OF OPERATION 2-9			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (I) this hospital attended the deceased from 6-6 , 19 79 , to 7-9 , 19 79 , that (I) (was) last saw the deceased alive on 7-8 , 19 79 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jael L. Rosenthal			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-9-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jael L. ROSENTHAL			22e. ADDRESS 363 So Cleveland HAGERSTOWN, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-12-79		23c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		23d. LOCATION CITY OR TOWN Neelyton COUNTY Huntingdon STATE PA			
24. FUNERAL DIRECTOR NAME Martin R. Brown			ADDRESS Ridgley St. Orbisonia, PA			25a. DATE RECEIVED BY REGISTRAR JUL 16 1979		25b. BY Hester		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 4 0 7

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MIDDLE LAST Wilbur Hamilton ROBINSON		Male		White	
5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
June 21, 1893		86		YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Md.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Hagerstown		271 S. Prospect St.		Carmen	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. INSIDE CITY LIMITS?	
Railroad		271 S. Prospect St.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Wash.		Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
George Albert Robinson		Margaret Alice Toms		yes	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
218-07-8697		Mrs. Sandra L. Wise, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes yrs yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): none					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
None		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
YES <input type="checkbox"/> NO <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
none		-- -- -- -- --			
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 72, to July 19 79, that (I) (we) lost saw the deceased alive on July 13 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. W. Lesh M.D.				22c. DATE SIGNED 7-17-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
William W. Lesh M.D.				411 Division Ave Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		July 18, 1979		Smithsburg Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Smithsburg, Wash. Md.		JUL 19 1979			
24. FUNERAL DIRECTOR (NAME)		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Davis Funeral Home, Smithsburg, Maryland				JUL 19 1979	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 8 4 0 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Perry Rosenmerkel					2a. DATE OF DEATH MONTH DAY YEAR July 11, 1979			2b. HOUR 1:30 P.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 26, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 22 Lakeside Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adjuster		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 22 Lakeside Drive			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown						
14. FATHER'S NAME FIRST MIDDLE LAST Perry Rosenmerkel					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Dodd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Nancy Rosenmerkel, Hagerstown, Md.		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Colon, Metastases 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Thyroid cancer										
19a. DATE OF OPERATION July 11		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Thyroid cancer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from July 11, 1979 , to July 11, 1979 , that I (we) last saw the deceased alive on July 11, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dalton M. Welty					DEGREE M.D.		22c. DATE SIGNED 7-11-79		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dalton M. Welty, M.D.					22e. ADDRESS 998 Potomac Ave., Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/79		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland, Md.			
24. FUNERAL DIRECTOR NAME William G. Kight					ADDRESS Cumberland, Md.		25a. DATE REC'D. BY REGISTRAR JUL 20 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 18409

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
James Lewis Rowland			July 6, 1979			10 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
male	white	February 3, 1925	54 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.				Washington MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown	Washington County Hospital			Rowland Chain Saw			owner	
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			
Maryland			Washington	Clearspring	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Amos James Rowland Sr.			Minnie Mae Clopper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
no						Mrs. Anna L. Rowland (same as 13c)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> years DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>July 6</u> , 19 <u>79</u> , that (I) <u>(was)</u> last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> (did not) view the body after death.								
22b. SIGNATURE <u>Charles Q. Spencer M.D.</u>						22c. DATE SIGNED 7-7-79		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Q. Spencer						22d. ADDRESS 138 E. Antietam St. Hagerstown		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
burial			July 10, 1979			Blairs Valley Cemetery		
						23d. LOCATION CITY OR TOWN COUNTY STATE		
						Blairs Valley Washington MD		
24. FUNERAL DIRECTOR NAME Osborne Funeral Home P.O. box 348 Wmspt., MD						25a. DATE REC'D. BY REGISTRAR JUL 17 1979		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Quay Jabeg Sagle			2a. DATE OF DEATH MONTH DAY YEAR July 24, 1979			2b. HOUR P M 1:40 P				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 17, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD				
10 CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Western Maryland Hospital Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1614 Dual Highway	
14 FATHER'S NAME FIRST MIDDLE LAST Arron T. Sagle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pleasant J. Myers							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17 INFORMANT Robert Sagle (son)		ADDRESS 5207 Bradley Blvd Bethesda, Md, 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease; myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months years										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d): Resected carcinoma of colon, Uremia, Nephrosclerosis										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 19 , 19 77 , to July 24 , 19 79 , that (b) <input checked="" type="checkbox"/> lost saw the deceased alive on July 24 , 19 79 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (l) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.										
22b. SIGNATURE <i>Florie P Palomo</i> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/25/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Florie P Palomo, MD				22e. ADDRESS 1500 Pennsylvania Ave Hagerstown						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-28-79		23c. NAME OF CEMETERY OR CREMATORY Res t Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Washington, Md.				
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc. Hagerstown, Md.				ADDRESS Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 1 8 4 1 1 REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Anna		Ruth		SCHINDEL				July 29, 1979		7:00 AM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
female		white		July 30, 1895		83 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Washington MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		Garlock Nursing Home						stenographer		railroad	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Maryland		Baltimore		Elkridge		YES <input type="checkbox"/> NO <input type="checkbox"/>		6287 Lawyers Hill Road			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Charles A. Trone		Mary J. Wolfe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS					
No		214-09-4058D		Mrs. Jeannette Hoffman, Elkridge, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Arthritis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> 19 <u>72</u> , to <u>7/29</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/29</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE		DEGREE		22b. ADDRESS				22c. DATE SIGNED			
<u>Edmund Hovesteen</u>				<u>100 W. Water Funkstown Md</u>				<u>7/31/79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
burial		Aug. 1, 1979		Funkstown Cemetery		Funkstown, Wash., Maryland					
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740						AUG 6 1979 <u>Hickory McCreedy</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 7918412									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Carrie Estelle		SELBEE						July 26, 1979		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
female		white		October 5, 1894		84					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				Washington MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		658 Virginia Ave.						millinery		dept. store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		658 Virginia Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
William Smelser				Betty Price							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
no				212-18-1252		Mrs. Jane Sweeney, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>3 pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>spontaneous</u>	
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACVD</u>										yes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1979</u> to <u>July 26, 1979</u> , that (I) (we) lost the deceased alive on <u>July 27, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED			
<u>L Waldron M.D.</u>								<u>7/26/79</u>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS							
<u>L WALDRON M.D.</u>				<u>138 E Antietam St.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
burial		July 28, 1979		Rest Haven Cemetery		Hagerstown, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR SIGNATURE			
Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md.						JUL 31 1979		<u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 18413	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara Elva Shank						2a. DATE OF DEATH MONTH DAY YEAR 7 / 13 / 1979			2b. HOUR 8:50 PM		
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH MONTH DAY YEAR 1 / 30 / 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? V.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington Co. MD.					
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fahrney Keedy Mem. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) R. N.		12b. KIND OF BUSINESS OR INDUSTRY Service			
13a. STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Maugensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS North Street			
14. FATHER'S NAME FIRST MIDDLE LAST Noah S. Shank				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace V. Neikirk							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W. I		16b. SOCIAL SECURITY NO. 212-22-9346		17. INFORMANT Linda G. Shank		ADDRESS 222 South Potomac Street Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ABCVD 3989 DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) UTI, Abx Antic Mening										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ ~	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 78 to July 13 19 79 that (I) (we) last saw the deceased alive on 6-2 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE V. Datta				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-14-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Datta				22e. ADDRESS 1600 Oak Hill Ave. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-17-79		23c. NAME OF CEMETERY OR CREMATORY Broadfording Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Broadfording, Washington, Md.					
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.						ADDRESS Hagerstown, Md.					
25a. DATE REC'D. BY REGISTRAR JUL 20 1979						REGISTRAR'S SIGNATURE Kirkley McCreedy					

BP

18413

State
Alva
Canton
Female
V.I.A.
Washington Co.
Hoonah
E. N.
North Yukon
Ketchikan
V.
Grace
Ed. Ross 212-22-9346
222 South Fort Street
Ketchikan

21240
1600 Oak Hill Ave. Haverston, Mo.
Dr. Datta
7-12-72
Broadcasting Company, Haverston, Mo.
J. I. Collins, Haverston, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 18414								
1. DECEASED NAME (TYPE OR PRINT) RILEY, Burnett					2a. DATE OF DEATH MONTH DAY YEAR 7 13 79					2b. HOUR 1:55 PM
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. HOUR 1:55 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hardwood Flooring		12b. KIND OF BUSINESS OR INDUSTRY Lumber Grader		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Williamsport		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lee Shingleton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ganoe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-09-7009		17. INFORMANT ADDRESS Emojean Moore Rt. 2 Box 150 Hag., MD 21740						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> <u>5990</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Urinary infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> 19 <u>79</u> to <u>July 10</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (Two doctors did not see the body after death.)										
22b. SIGNATURE <u>Hyatt J. Shingleton</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 18, 1979		23c. NAME OF CEMETERY OR CREMATORY Old Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Romney Hampshire W. Virginia				
24. FUNERAL DIRECTOR NAME Osborn Funeral Home P.O. Box 348 ADDRESS Wmspt., MD					25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE <u>Barney McCready</u>			

1 1 1 1 1

RECEIVED



1 1 1 1 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 1 8 4 1 5	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Russell Shumaker						2a. DATE OF DEATH MONTH DAY YEAR July 11, 1979		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-28-1905		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1732 Edgewood Hills Circle				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cattle buyer		12b. KIND OF BUSINESS OR INDUSTRY Swift & Co.			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1732 Edgewood Hills Circle			
14. FATHER'S NAME FIRST MIDDLE LAST Austin - - Shumaker						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 172015451		17. INFORMANT ADDRESS Mrs. Edith I. Shumaker see # 13							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one hour 10 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from May 29 , 19 79 , to July 11 , 19 79 , that (1) (we) lost saw the deceased May 29 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If "we" lost, did not, view the body, after, etc.)											
22b. SIGNATURE Robert Brull						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Brull, M.D.						22e. ADDRESS 138 E. Antietam St., Hagerstown, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-13-79		23c. NAME OF CEMETERY OR CREMATORY Shenandoah Me. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Winchester, Va.					
24. FUNERAL DIRECTOR NAME Gerald N. Minnich Hagerstown, Maryland						305 N. Potomac St. ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE Pickney McBrady	

BP

1 8 4 1 5

July 11, 1975

Robert J. Jensen

Washington

DBA

Phone

1715 Longwood Hill is located in the city of Washington, D.C.

1715 Longwood Hill is located in the city of Washington, D.C.

Robert J. Jensen

1715 Longwood Hill is located in the city of Washington, D.C.

[Handwritten signature]

1715 Longwood Hill is located in the city of Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
Josephine		Slye		22 July 1979		1035 AM					
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR		8 UNDER 24 HRS			
Female	Caucasian	7-26-29		49		MONTHS DAYS		HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD.	US			Washington				MD.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY						
Hagerstown	Western Maryland Center		housewife		home						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
Md		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				111 E. Baltimore St.	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Hubert - Wolfe		Della Mae Lewis									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS					
NO		217 28 6096		Linda K. Slye		428 Mitchell Ave Hagerstown, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia, pulmonary emboli</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>septic mural thromb ventricles</u> <u>degenerative spinal muscular atrophy</u> PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>perineal ulcer with respiratory failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u> <u>0 months</u>	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
NA		NA		NA							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
NA		NA		NA							
22a I certify that (I) (this hospital) attended the deceased from <u>6/7</u> 19 <u>79</u> , to <u>7/23</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>7/22</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED					
Flores P. Palomo md						7/23/79					
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS									
Floresita P. Palomo, md		1500 Pennsylvania Ave Hagerstown, Md 21740									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		7-25-79		Rest Haven Cem.		Hagerstown, Md					
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Gerald N. Minnich		305 N. Potomac St Hagerstown, Md		JUL 31 1979		Patsy McBratney					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18417

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED		2c. DATE PRONOUNCED DEAD		2d. HOUR		
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. DATE ESTIMATED		2c. DATE PRONOUNCED DEAD		2d. HOUR		
EARL R. SMITH		JUNE 30 1979		JUNE 30 1979		1:00 PM				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH				
Male	White	March 7, 1939	40 YRS.			Washington County, MD				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.		X NEVER MARRIED		Washington County, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Hagerstown		Route 4, Broadfording Road		Foundry		Poll. Con.				
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS				
Maryland		Washington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #4, Box 165				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
John Henry Smith		Lucille Johnson		219-34-5242		Edna M. Smith, Rt. 4, Box 165				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		219-34-5242		Edna M. Smith, Rt. 4, Box 165						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		ACUTE AND SUBACUTE FORM OF ISCHEMIC HEART DISEASE		5-10 YRS.				
410-		DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF						
		(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		JULY 3, 1979				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		217 W. WASHINGTON ST. HAGERSTOWN, MD. 21741						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		7-3-79		Rest Haven Cemetery		Hagerstown, Wash., Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Rest Haven Funeral Chapel, Inc., Hag., Md.		JUL 6 1979		25b. REGISTRAR'S SIGNATURE		Hofrey McCready				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 8 4 1 8					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MIDDLE LAST Robert Martin Smith					MONTH DAY YEAR July 16, 1979					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		White		May 3, 1917		62		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Washington County, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		331 Elizabeth Avenue				Engineer		Railroad		
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland					Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Walter Martin					FIRST MIDDLE LAST Annie Martin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes					WW II		214-09-8805 Joan A. Shank, 1033 Beechwood Dr.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)										
PART I. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) Cardiac Arrest										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Coronary atherosclerosis										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Diabetes Mellitus										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Old CVA										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
none			-----			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			P.M. none 19			- - - - -				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
			none			- - - - -				
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1972 to July 1979, that (I) (we) lost saw the deceased alive on July 13, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
WW Lesh M.D.								7-17-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
William W. Lesh M.D.					411 Division Avenue Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			7-18-79		Rest Haven Cemetery		Hagerstown, Wash., Md.			
24. FUNERAL DIRECTOR					25a. DATE DIRECTOR RECEIVED CAR					
NAME ADDRESS Rest Haven Funeral Chapel, Inc., Hag., Md.					JUL 19 1979					

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2025 COLLECTION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 1 8 4 1 9
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Rachel Pauline Snowberger</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>July 24, 1979</i>		2b. HOUR <i>5 45</i> M
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1/1/1903</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>AVALON Manor Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>
13a. STATE <i>Md.</i>			13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Smithsburg</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>John H. Snowberger</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma Pryor</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>219-54-2431</i>		17. INFORMANT ADDRESS <i>Charles R. Punt 54 N. Main St. Smithsburg, Md.</i>	

MEDICAL CERTIFICATION	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arterioclototic cerebrovascular disease</i> <i>4370</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Disease with cerebral degeneration</i> (c) <i>arteriosclerosis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Degenerative joint disease</i>					
	19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
	21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
	22a. I certify that (I) (this hospital) attended the deceased from <i>7/17</i> , 19 <i>75</i> , to <i>7/23</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>7/30</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not see the body after death.					
	22b. SIGNATURE <i>R. Amarillo</i>		DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/24/79</i>	
	22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. AMARILLO</i>		22e. ADDRESS <i>127 King St. Hagerstown, Md.</i>			
	23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/26/1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill</i>	
	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Waynesboro Franklin Penna.</i>		24. FUNERAL DIRECTOR <i>David J. Stone</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 30 1979</i>	
25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>		ADDRESS <i>50 S. Broad St. Waynesboro, Pa.</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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Handwritten notes and signatures, including the word "MAY" and various illegible scribbles.



1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 8 4 2 0

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Ira</u> MIDDLE: <u>Frank</u> LAST: <u>Snyder</u>			2a. DATE OF DEATH MONTH: <u>July</u> DAY: <u>31</u> YEAR: <u>1979</u> 2b. HOUR: <u>11:30</u> AM	
3. SEX <u>male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH: <u>Jan.</u> DAY: <u>3</u> YEAR: <u>1912</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>67</u> YRS. IF UNDER 1 YEAR: MONTHS: <u></u> DAYS: <u></u> IF UNDER 24 HRS: HOURS: <u></u> MIN: <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD.	
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Maintenance</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Products</u>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE <u>Md.</u>	13b. COUNTY <u>Wash.</u>	13c. CITY OR TOWN <u>Chewsville</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>Box 11</u>
14. FATHER'S NAME FIRST: <u>John</u> MIDDLE: <u></u> LAST: <u>Snyder</u>		15. MOTHER'S MAIDEN NAME FIRST: <u>Emma</u> MIDDLE: <u>Catherine</u> LAST: <u>Strite</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>yes</u> (IF YES, GIVE WAR OR DATES) <u>WW II</u>		16b. SOCIAL SECURITY NO. <u>188-09-5109</u>	17. INFORMANT ADDRESS <u>Mr. James F. Snyder Smithsburg, Md.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>1889</u> IMMEDIATE CAUSE (a) <u>Metastatic Bladder Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>seven years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>				
19a. DATE OF OPERATION <u>July 22, 1979</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> <u></u> <u></u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u></u>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u></u>		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u></u> <u></u> <u></u> <u></u>		22a. I certify that <u>0</u> (this hospital) attended the deceased from <u>July 22</u> , 19 <u>79</u> , to <u>July 31</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <u>Robert Brull</u>		22c. DATE SIGNED <u>August 1, 1979</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Brull</u>
22e. ADDRESS <u>138 E. Antietam St.</u>		22f. CITY OR TOWN <u>Hagerstown</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Aug. 4, 1979</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Smithsburg</u> <u>Wash.</u> <u>Md.</u>		24. FUNERAL DIRECTOR NAME <u>Davis Funeral Home</u> ADDRESS <u>Smithsburg, Md.</u>		
25a. DATE REC'D. BY REGISTRAR <u>AUG 6 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Hickory McCreedy</u>		

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. AIR FORCE
HEADQUARTERS
AFMPC
WRIGHT-PATTERSON AFB
OHIO



05081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 333-2100.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 1 8 4 2 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLINTON VICTOR SPICKLER					2a. DATE OF DEATH MONTH DAY YEAR July 17, 1979			2b. HOUR 1:05 PM		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 25, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) tool & die maker		12b. KIND OF BUSINESS OR INDUSTRY Aircraft fact		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey O. Spickler					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Pitenger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-09-9842		17. INFORMANT ADDRESS Louise J. Spickler, Hagerstown, Md.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 410- DUE TO, OR AS A CONSEQUENCE OF ACUTE MYOCARDIAL INFARCTION 10 days (b) } (c) } DUE TO, OR AS A CONSEQUENCE OF ATHEROSCLEROTIC CARDIO-VASC DLS. 2 WEEKS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) NEPHROTIC SYNDROME										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from February 19, 1979, to 7.16.79, that (I) (we) lost saw the deceased alive on 7.16.79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature] DEGREE					22c. DATE SIGNED 7-17-79			22d. PHYSICIAN'S NAME (TYPE OR PRINT) OTTO ROZA MD.		
22e. ADDRESS 100 LONG MEADOW DRIVE WASH HAGERSTOWN MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE July 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash., Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 21740					25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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THICKNESS

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AT THE HIGHEST ELEVATION

AT THE HIGHEST ELEVATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 8 4 2 2

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		July 11, 1979		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		Oct. 9, 1888		90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md., Md.		USA		Washington		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown		835 W. Franklin St.		machinists		shipbuilding	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Edgar Randolph Sponseller		Clara -- Burton		no		579 54 3831	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Other Sclerotic Heart Disease</i> 4140 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last DUE TO OR AS A CONSEQUENCE OF (b) <i>General Sclerosis</i> DUE TO OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Citronia of Prostate</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 15 yrs.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
None		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR None		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) None		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) None		21f. LOCATION STREET CITY OR TOWN COUNTY STATE None Hagerstown MD		22a. I certify that (1) this hospital attended the deceased from 19 79 to 19 79, that (1) (we) lost saw the deceased alive on and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE J. H. Beachley M.D. 22c. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. Beachley M.D.	
22d. DATE SIGNED July 11/79		22e. ADDRESS Hagerstown MD		22f. MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED July 11/79	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7-13-79		Rest Haven Cemetery		Hagerstown, Maryland	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Gerald N. Minnich		305 N. Potomac St. Hagerstown, Maryland		JUL 23 1979		R. H. McCready	

1 3 4 2 2

July 12, 1953

Arthur Oliver Scott

20

Oct. 9, 1953

614

614

Washington

124

124

Washington

830 A. Franklin St.

Washington

Lyons Washington

Arthur Oliver Scott

20

Herold J. Hinkle
President, National
Board of Directors
1-12-53
1000 Avenue of the Americas, New York 10
1000 Avenue of the Americas, New York 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 8 4 2 3 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MARGARET D. Staeblein					2a. DATE OF DEATH MONTH DAY YEAR July 13, 1979			2b. HOUR 12:00pm	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 16, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON CO. MD.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON COUNTY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY — 13c. CITY OR TOWN BALTIMORE					13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2460 MAYFIELD AVE 21215		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD C. DIENL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST — PORICK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS EDWARD T. STAEBLEIN, SMITHSBURG MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4140 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) —								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): gross - mesenteric Artery Thrombosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-13 19 79 to 7-13 19 79 , that (I) was lost saw the deceased alive on 7-15 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death.									
22b. SIGNATURE John H. Hornbaker Jr. MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-14-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John H. Hornbaker Jr.					22e. ADDRESS 645 E. First Street, Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12 July 79		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO CO. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS Uecker Funeral Home, Balto MD 21206					25a. DATE REC'D. BY REGISTRAR JUL 17 1979		25b. REGISTRAR'S SIGNATURE John H. Hornbaker Jr.		

1875

12:00 PM July 13, 1875

Received of Mr. J. H. Thompson
the sum of \$100.00
for the purchase of
the land on which
the building is
situated. This
sum is to be
applied to the
purchase of the
land on which
the building is
situated.

Witness my hand and seal
this 13th day of July 1875
John H. Thompson

(M)

100% COTTON FIBER

MADE IN U.S.A.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

1 8 4 2 4

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Stefano, Frank Francis Stefano, Sr.</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>7-23-79</u>			2b. HOUR <u>1:15 PM</u>				
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>5-23-14</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>65</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New York</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Washington</u> MD				
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Washington County Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Supervisor</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>2360 Appletree Drive</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Joseph Stefano</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Margaret Perry</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>				
16b. SOCIAL SECURITY NO. <u>050-01-2828</u>			17. INFORMANT ADDRESS <u>Angelina Stefano, 2360 Appletree Dr.</u>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute anterior myocardial infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>many years</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) <u>Previous myocardial infarction</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> , 19 <u>79</u> , to <u>July 23</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>July 23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edson B. Moody M.D.</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/23/79</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edson B. Moody M.D.</u>			22e. ADDRESS <u>RT #3 Box 163 Hagerstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>7-25-79</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hagerstown, Wash., Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Rest Haven Funeral Chapel, Inc., Hag., Md.</u>			ADDRESS <u>MD</u>			25a. DATE REC'D. BY REGISTRAR <u>JUL 27 1979</u>		25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR					REG. NO. 79 18425					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH IRENE STROCK					2a. DATE OF DEATH MONTH DAY YEAR JULY 19 1979					2b. HOUR 8:05A.M.
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 2 7 90		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 650 Oak Hill Avenue			
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown						
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Calvin Strock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Barbara Hoffman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 200-22-5271		17. INFORMANT Helen M. Betts		ADDRESS 7 Redwood Circle Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BOWEL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. 1539										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/18 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from 7/18 19 79 , to 7/19 19 79 , that (I) (we) last saw the deceased alive on 7/18 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did), did not view the body after death.										
22b. SIGNATURE Charles R. Chaney M.D.					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES R. CHANEY M.D.					22e. ADDRESS 119 King Street, Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-21-79		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Washington, Md.				
24. FUNERAL DIRECTOR NAME A. K. Coffman Funeral Home, Inc.					ADDRESS Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR JUL 23 1979		25b. REGISTRAR'S SIGNATURE Robert McCreedy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 8 4 2 6 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Violetta NMN Sucenay</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>July 31 1979</i>		2b. HOUR <i>7 4 M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 19, 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Trego, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington County Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1037 Florida Ave.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Nelson Holmes</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Susan Smith</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-10-3769D</i>		17. INFORMANT ADDRESS <i>Mrs. Roxanne Collison, 1037 Florida Ave. Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>2500</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetic Cardiomyopathy</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (c) <i>1 yr.</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Renal Failure, Diabetes mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>June 19 79</i> to <i>July 31 19 79</i> , that (I) (we) last saw the deceased alive on <i>July 30 19 79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <i>Charles J. Spencer</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles J. Spencer</i>						22e. ADDRESS <i>138 E. Antietam St., Hagerstown, Md. 21740</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-3-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Samples Manor Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Samples Manor, Wash. Co., Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>John H. Bast, Jr. Boonsboro, Md. 21713</i>						25a. DATE REC'D. BY REGISTRAR <i>AUG 6 1979</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			7 9 1 8 4 2 7				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) John Calvin Sword Jr.			2a DATE OF DEATH MONTH DAY YEAR July 1, 1979				2b HOUR 12:30			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 4, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.				
10 CITY OR TOWN OF DEATH Clearspring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD-2				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Officer		12b KIND OF BUSINESS OR INDUSTRY Police		
13a STATE Maryland			13b COUNTY Washington		13c CITY OR TOWN Clearspring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS RFD-2	
14 FATHER'S NAME FIRST MIDDLE LAST John Calvin Sword Sr.			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie T. Bricker							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-10-6928		17 INFORMANT ADDRESS Mrs. Verda Sword Clearspring, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension mild</u> PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 4 yrs. 5 yrs.		
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE Masson B. Alizaoh				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 7/17/79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) MASSON B. ALIZAOEH				22e ADDRESS 318-N. Potomac St. Hagerstown Md.						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE July 4, 79		23c NAME OF CEMETERY OR CREMATORY Blairs Valley		23d LOCATION CITY OR TOWN COUNTY STATE Clearspring, Wash. Md.				
24 FUNERAL DIRECTOR Thompson Funeral Home				24b ADDRESS Clearspring, Md.		25a DATE REC'D BY REGISTRAR JUL 23 1979		25b REGISTRAR'S SIGNATURE [Signature]		

15. 81 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR			7 9 1 8 4 2 8 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST Edith		MIDDLE		LAST Thomas		2a. DATE OF DEATH MONTH DAY YEAR 7-17-79		2b. HOUR 2 A. M.	
3. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 17 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH PLACE, GIVE STREET ADDRESS) State Hospital Hagerstown				12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md			13b. COUNTY Washington			13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME MIDDLE William Lee						15. MOTHER'S MAIDEN NAME MIDDLE Wilhelmina Shuhart						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Charles Thomas Lonaconing, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure - Uterus - 5500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks Many years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 7-16-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE W.W. Lesh MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.W. Lesh						22e. ADDRESS Hagerstown, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/20/79		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Moscow A. Md				
24. FUNERAL DIRECTOR Eichhorn Funeral Home						ADDRESS Lonaconing, Md.			25a. DATE REC'D. BY REGISTRAR JUL 20 1979			
						25b. REGISTRAR'S SIGNATURE [Signature]						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 18429				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDGAR RAYMOND TOMS					2a. DATE OF DEATH MONTH DAY YEAR July 2, 1979			2b. HOUR 12:40 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct 6, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY Electric Co.	
13a. STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1400 Virginia Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Millard F. Toms					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie E. Leatherman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. I		17. INFORMANT Mrs Violet P. Toms		ADDRESS 1400 Virginia Ave Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 436- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 29, 1979 to July 2, 1979 , that (I) (we) last saw the deceased alive on July 1, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) GLORIA F. PURA				22c. ADDRESS 382 S. CLEVELAND				22e. DATE SIGNED July 2, 1979	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-5-79		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sharpsburg, Washington, Md.			
24. FUNERAL DIRECTOR NAME A.K. Coffman Funeral Home, Inc.				ADDRESS Hagerstown, Md.		25a. DATE REC'D. BY REGISTRAR JUL 9 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony Maloney</i>	

BP

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Washington County

W. A.

Washington

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Washington County Hospital

Hagerstown

1400 Virginia Avenue

Washington Hagerstown

Washington

Lawrence

Little

Town

T.

Millard

1400 Virginia Ave

1st Victor R. Lane Hagerstown, Md.

1514-16-1030

W. A. I

for

Washington, Maryland

W. A. View

7-5-77

Serial

U. S. National Bureau of Investigation, Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 18430			
1- FOR STATE REGISTRAR		REG. NO.											
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
Andrew R. Tuzzio								7		6	79	M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		10-22-1910		68		YRS		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						MD.	
New Jersey		USA				Washington							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Washington Co. Hospital		repairman		truck							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a COUNTY		13b CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS					
Maryland		Washington		Hagerstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		133 Pheasant Trail					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
Charles - - Tuzzio		Viola - - Mersecola											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
no		150 05 0395		Mrs. Orita Tuzzio		see # 13							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial Infarction										2d			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Antecedent atherosclerotic Heart Disease										yrs			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M.		19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-5, 19 70, to 7-6, 19 79, that (I) (we) lost													
saw the deceased alive on 7-5, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
J. Minnich		MD				7-6-79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Gerald N. Minnich		305 N. Potomac St.		JUL 12 1979									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		7-10-79		Mt. Carmel Cemetery		W. Long Branch, N. J.							
24 FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRY		25b. REGISTRAR'S SIGNATURE									
NAME		ADDRESS											
Gerald N. Minnich		305 N. Potomac St.		Funeral Home Hag.md.									



1-22-1910

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

7 9 1 8 4 3 1

1. DECEASED NAME (TYPE OR PRINT) Emily Louise WEBB			2a. DATE OF DEATH MONTH DAY YEAR 7 18 79		2b. HOUR 4:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Washington MD	
12. CITY OR TOWN OF DEATH Hagerstown		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co. Gen. Hospital		14a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse	14b. KIND OF BUSINESS OR INDUSTRY School
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Md.		15b. COUNTY CARROLL	15c. CITY OR TOWN Mt. Airy	15d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	15e. STREET ADDRESS 507 S. MAIN ST.
16. FATHER'S NAME FIRST MIDDLE LAST Dorsey Stackhouse		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Frost			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		19. INFORMANT Nathan Webb ADDRESS Westminster, Md.	
20. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 410 - DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Obstructive Jaundice Due to Cholelithiasis					
21a. DATE OF OPERATION 7/5/79		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED obstructive Jaundice		21c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
23a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23c. LOCATION STREET CITY OR TOWN COUNTY STATE	
24. I certify that (I) (this hospital) attended the deceased from July 2, 1979, to July 19, 1979, that (I) (we) last saw the deceased alive on July 18, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
25a. SIGNATURE E. C. Sullivan MD		25b. DEGREE MD		25c. DATE SIGNED 7/19/79	
26a. PHYSICIAN'S NAME (TYPE OR PRINT) E. C. Sullivan MD		26b. ADDRESS 239 N. Potomac St. Hagerstown MD			
27a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		27b. DATE 7-21-79		27c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	
27d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown Howard Md.		28a. DATE REC'D. BY REGISTRAR JUL 25 1979		28b. REGISTRAR'S SIGNATURE L. J. McCreedy	
29. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Sykesville, Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 1 8 4 3 2		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PATRICIA ANN WIBLE				2a. DATE OF DEATH MONTH DAY YEAR July 19, 1979		2b. HOUR 4:08 A.M.			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 23, 1947		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 31		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Washington County MD.			
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Franchise	
13a. STATE Penna.				13b. COUNTY Franklin		13c. CITY OR TOWN Chambersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 145 North Franklin Street									
14 FATHER'S NAME FIRST MIDDLE LAST Samuel K. Hammond				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Leedy					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO. 195-367456		17. INFORMANT ADDRESS Ronald E. Wible 145 N. Franklin St. Chambersburg -rg, Pa. 17201			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a). Metastatic breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b). Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frederic H. Kass T.L.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass T.L.				22e. ADDRESS 1825 Towell Rd Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 21, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Thomas Franklin Pa.			
24 FUNERAL DIRECTOR NAME John O. Park				ADDRESS 152 S. 2nd St. Chambersburg, Pa.		25a. DATE REC'D. BY REGISTRAR JUL 24 1979		25b. REGISTRAR'S SIGNATURE Rafaela K. Brady	

1848



1848

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

FOR
1- STATE REGISTRAR
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 8 4 3 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR	
STENNIS		ALINE		WILSON				July 11		19		79		3:30		PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
female	white	Jan 19, 1919		60		YRS.		MONTHS		DAYS		HOURS		MIN		July 11 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		<input checked="" type="checkbox"/> NEVER MARRIED		<input type="checkbox"/> WIDOWED		<input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
MISS.		USA										WASHINGTON COUNT		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Big Pool, Md.		none		housewife													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		606 Myrth Ave.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Hendrick		COTTIE BELL CURRIN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		42807264		E.B.Wilson(husband)		same as wife.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Asphyxiation by suffocation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		minutes									
		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)		DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
none		none															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		3:30 P.M. Jul 11 19 79		Trailer home deceased was driving overturned													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
		highway		Interstate 70, near Big Pool, Washington, Md.													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Francisco G. Japzon		TITLE (SPECIFY) Asst.		MEDICAL EXAMINER		DATE SIGNED		July 12, 1979							
EXAMINER'S NAME (TYPE OR PRINT)		Francisco G. Japzon, M.D.		ADDRESS		645 E. First St. Hagerstown, Md. 21740											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		7/14/79		BELAIR		BELAIR MD.											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
CONNELLY F.H.		300 MACE AVE		JUL 18 1979		R. J. Hager											



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 8 4 3 4

1 DECEASED NAME (TYPE OR PRINT) Edna Grace Wishard			2a DATE OF DEATH MONTH DAY YEAR July 14 1979 2b HOUR 6 P.		
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Aug. 5, 1893	6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Washington MD.		
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington County Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Washington 13c CITY OR TOWN Williamsport		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 2750 Virginia Ave.		
14 FATHER'S NAME FIRST MIDDLE LAST Charles U. Nufer		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha V. Martin			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO 219-54-0272		17 INFORMANT ADDRESS Hagerstown, Md. 21740 Mr. Donald Wishard 224 Rock Willow Ave.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 4/10 - DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery dis 1 year DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic Cardio. Dis years.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) - Cerebral thrombosis & R. Compens.					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE date	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 14 Aug 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we added, did not view the body after death).					
22b SIGNATURE Richard P. Smith		22c ADDRESS 151 N. for		22d DATE SIGNED 14 Aug 79	
22e PHYSICIAN'S NAME (TYPE OR PRINT) 151 N. for		22f ADDRESS Hagerstown Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 7/18/1979	23c NAME OF CEMETERY OR CREMATORY Green Hill		23d LOCATION CITY OR TOWN COUNTY STATE Waynesboro Franklin Penna.	
24 FUNERAL DIRECTOR NAME David G. Grier		ADDRESS Waynesboro, Penna.		25a DATE RECEIVED BY REGISTRY JUL 19 1979	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

4-21-61

CONFIDENTIAL



x

545-41-017

17/1/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR		7 9 1 8 4 3 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Naomi Elizabeth Wolfinger						2a. DATE OF DEATH MONTH DAY YEAR 7-21-79		2b. HOUR 9:55 ^{AM}	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR October 4, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Co Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Acct Corp		12b. KIND OF BUSINESS OR INDUSTRY Loan	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob E Royer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Susan Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-09-7611		17. INFORMANT ADDRESS Mrs Katherine Carl Sheenath, R					
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292 Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCA - Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frederic H. Kass III						DEGREE MD		22c. DATE SIGNED 7/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederic H. Kass III						22e. ADDRESS 1825 Howell Rd Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/25/1979		23c. NAME OF CEMETERY OR CREMATORY Eden Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis Prince Georges Penna			
24. FUNERAL DIRECTOR NAME Shawel H. Zimmerman						ADDRESS Sheenath, R		25. DATE RECEIVED BY REGISTRAR JUL 26 1979	
						26. REGISTRAR'S SIGNATURE H. H. H. H.			

MEDICAL CERTIFICATION

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible due to fading and bleed-through from the reverse side of the page. It appears to be a memorandum or letter with several paragraphs of text.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR REGISTERAR		REG. NO. 18436							
1 DECEASED NAME (TYPE OR PRINT) <i>Charles Landrum Yelverton</i>					2a DATE OF DEATH MONTH DAY YEAR <i>7-11-79</i>			2b HOUR <i>1225 PM</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>March 27 1900</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>South Carolina</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Washington</i> MD.			
10 CITY OR TOWN OF DEATH <i>Hagerstown</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Western Maryland Center</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sheet metal worker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Pangborn</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i> 13b COUNTY <i>Washington</i> 13c CITY OR TOWN <i>Hagerstown</i>					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <i>64 Devonshire Road</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>Wily W. Yelverton</i>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nannie Salter</i>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unknown</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-09-8076</i>		17 INFORMANT ADDRESS <i>Mary Eva Yelverton, 64 Devonshire Road, Hagerstown, MD 21740</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiorespiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of lung Lt with</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>leucine metastasis</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION <i>NA</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <i>7-6-79</i> to <i>7-11-79</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b SIGNATURE <i>Florencia P Palomo</i>		DEGREE <i>M.D.</i>		22c DATE SIGNED <i>7-11-79</i>					
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Florencia P Palomo</i>		22e ADDRESS <i>1500 Penna Hagerstown</i>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>7-13-79</i>		23c NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d LOCATION <i>Hagerstown, Wash., Md.</i>			
24 FUNERAL DIRECTOR NAME <i>Rest Haven Funeral Chapel, Inc., Hag., Md.</i>				25a DATE REC'D. BY REGISTRAR <i>JUL 16 1979</i>		25b REGISTRAR'S SIGNATURE <i>Richard [Signature]</i>			

6 5 4 3 2 1

Charles Lindbergh

South Carolina USA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 7 9 1 8 4 3 7									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Margaret		MIDDLE NMN		LAST Youler		2a. DATE OF DEATH MONTH DAY YEAR July 24, 1979		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9- 15- 1883		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Washington MD.					
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Williamsport Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE W.Va.		13b. COUNTY Jefferson		13c. CITY OR TOWN Shenandoah Junction		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt 1, Box 129-3A			
14. FATHER'S NAME FIRST MIDDLE LAST John R, Watkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gwenllian Harris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NN		17. INFORMANT ADDRESS Mrs. Darwin Youler, Rt. 1, Box 129-3A Shenandoah Junction, W.Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> 4280 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>approx 6 wks</u> <u>years.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <u>3-25</u> , 19 <u>76</u> , to <u>7-24</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>7-23</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE <u>John R. Melnick</u>						DEGREE <u>MD</u>		22c. DATE SIGNED			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-26-79		23c. NAME OF CEMETERY OR CREMATORY Grandview		23d. LOCATION CITY OR TOWN Johnstown, Penn.		STATE			
24. FUNERAL DIRECTOR NAME David B. Jones, Rt 7 Martinsburg, W.Va.						25a. DATE REC'D. BY REGISTRAR JUL 31 1979		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 1 8 4 3 8 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) LUCY CATHERINE YOUNKER				July 29, 1979 6:30 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 7-2-11		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WASHINGTON MD.	
10 CITY OR TOWN OF DEATH HANCOCK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ROUTE #2		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD. 13b. COUNTY WASH. 13c. CITY OR TOWN HANCOCK				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ROUTE #2	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM CHRISTOPHER SCHMIDT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ARIZONIA VICTORIA MICHAEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216 46 6794		17. INFORMANT ADDRESS JAMES L. YOUNKER, SR. SAME AS 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage							1 Hr
4549 DUE TO, OR AS A CONSEQUENCE OF (b) Varicose Veins							yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension, Obesity							
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. none 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) None			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) None		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 72, to July 29, 19 79, that (I) (we) last saw the deceased alive on Apr. 30, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W.W. Lesh M.D.				DEGREE		22c. DATE SIGNED 7-31-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Lesh M.D.				22e. ADDRESS 411 Division Ave Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/1/1979		23c. NAME OF CEMETERY OR CREMATORY STONE BRIDGE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HANCOCK, WASHINGTON, MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 6 1979		25b. REGISTRAR'S SIGNATURE	

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